Realizing the Potential of **HOME CARE**

Competing for Excellence by Rewarding Results

A Review of the competitive bidding process used by Ontario's Community Care Access Centres (CCACs) to select providers of goods and services

Acknowledgement from the Honourable Elinor Caplan, PC

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Message from the Chair

When I undertook the CCAC Procurement Review, I was determined to keep quality for the client and the needs of the family at the centre of this endeavour. I wanted the outcome of the recommendations, where possible, to be fact-based, to lead to greater continuity, consistency and streamlining of service. I also wanted to promote an environment of continuous improvement through the adoption of benchmarking and best practices. I believe that achieving these objectives will lead to greater stability in the workforce.

The Romanow Report calls home care the "next essential service." I wholeheartedly agree. Ontario residents deserve to have quality home care services available when they need them. It is time to ensure that we realize the potential of home care for the future. It is time to combine innovation and renewal in the interests of Ontario's home care clients and their families. During the CCAC Procurement Review, I was pleased to find that seven out of ten home care clients thought the quality of home care they received was excellent or good.

Building on this foundation, my mandate was to address the impact of the current procurement practices in home care on the quality of service, continuity of care, workforce stability and value to the taxpayers.

Home care in Ontario has long been the recipient of public funding through tax dollars. Like other health services, it has been primarily delivered by private (not-for-profit and for-profit) organizations. The Procurement Review accepts this basic premise and makes recommendations within this framework to improve the way that services are procured, delivered and received. The fact that home care is publicly funded and delivered by third parties should not be a surprise. Nor should it be a cause for concern as long as private sector participation in health care is monitored for quality as well as for ensuring that the profit motive does not overshadow appropriate care.

There is a need for balance in a competitive environment, and I believe the focus should be on well-managed procurement where competition is for quality first and price, second. The emphasis should be on achieving value for money.

I believe that the goal of delivering to Ontarians the best quality home care at the best value through good procurement practices is achievable. In order to reach that goal, we must have valid and reliable information, appropriate oversight mechanisms and the correct incentives in place to ensure quality care, at the best value within a well-managed procurement model.

Currently, there are a number of stumbling blocks preventing us from reaching this goal:

- Inability to collect and communicate standardized critical information needed to assess quality and deliver better client outcomes;
- Insufficient research to set benchmarks and identify best practices;
- Inconsistent procurement practices and too much duplication across CCACs;
- Frequent transitions between contracts resulting in instability in the sector;
- Inconsistent transition planning practices;
- Poor employment practices by some; and
- Disincentives for innovation, quality and access.

Any review of home care in Ontario must be considered in the context of (and not in isolation from) the hospital and primary care sectors. The end result should be to provide Ontarians with a seamless continuum of care, when needed, as close to home as possible. Developing a strong home care system is a key element in the Government's goal of transforming health care to a more community-oriented and results-based approach.

Quality home care support is vital, and should be at the centre of the health care system. It is where people want to be cared for, if at all possible. It is a pre-requisite for early discharge of patients from hospitals. Home care also provides an alternative to long-term care homes. Demand for home care will continue to increase as our population ages and as technology advances. For the overwhelming majority who prefer to remain in their community, home care is more humane, cost-effective, and more *health-*

effective. There is less chance of infection in a home environment. People are generally happier and recover faster, both physically and mentally, at home. Studies show that family-centred home care for palliative and end-of-life clients is preferred.

It is, therefore, both significant and of concern that home care funding has been declining as a percentage of total health care spending over the past number of years. However, the McGuinty Government's commitment to reverse this trend with the first new investment in the sector beginning in 2003/2004 is to be applauded.

During this review, as I listened to clients and their families, it became clear that they want a stronger voice in home care. They want to be part of the care team. They want to be active participants in decisions about their care.

It also became clear that both clients and caregivers would benefit from more stability in the workforce. Addressing continuity of care and continuity of caregiver were major focuses of this review.

In addition, a more satisfied workforce leads to better quality service for clients and, part of delivering satisfaction, comes from delivering choice. Workers want choice as well. Full-time and part-time work should both be encouraged and seen as valid employment practices. All employees should benefit from the protections of the Employment Standards Act.

I saw the valuable contribution that the not-for-profit sector has made to home care since its inception. I believe that their experience and expertise is an essential component of a vibrant home care sector. I also believe that the role of small providers and those providing additional community support services should be continued and encouraged in the home care sector.

I believe that the so-called "envelope funding" will foster innovation and better care because the best care is not always synonymous with the most number of visits by a caregiver. For that reason, the CCAC Procurement Review examines the establishment of an alternative-funding model.

Finally, in order to measure progress, improvements and success in the home care sector, I believe we need greater consistency in procurement procedures. I also believe that better information and new mechanisms for collecting and reporting information are essential to ensure well-informed policy in the future. Accurate information is the foundation on which to build a home care system that is focused on continuous improvement, innovation, and best practices. The ultimate goal must be to realize the potential of home care to deliver excellent quality care for clients and their families while getting good value for the taxpayer.

Hon. Elinor Caplan, PC

Executive Summary

The Goal: Improve home care - "the next essential service"

"The McGuinty Government is ensuring Ontarians receive the highest quality home care services by appointing the Honourable Elinor Caplan to conduct an independent review of the competitive bidding process used by Community Care Access Centres (CCACs) to select service providers."

– Hon. George Smitherman, Minister of Health and Long-Term Care, October 4, 2004

The Ministry of Health and Long Term Care provides, through its Community Health Division, transfer payments to 42 Community Care Access Centres, (CCACs) and to approximately 800 community support service (CSS) agencies for the delivery of community-based services. The funding is used to provide professional, homemaking and personal support services at home for people who would otherwise need to go to, or stay longer in, hospitals or long-term care homes. Funding is also provided to assist frail elderly people and people with disabilities to live as independent as possible in their own homes.

The Ministry provided approximately $1.6 billion for CCACs and CSS agencies in 2003/2004. In its recent report, the Office of the Provincial Auditor raised a number of concerns with home care in Ontario, including the need for a funding formula that more fully allocates funds based on assessed needs; measures to demonstrate clients are in fact receiving quality care; and an information system to collect client-level service and costing data.

We heard these same concerns from our consultation sessions, and from submissions to this review. In particular the desire for quality care was paramount in most discussions and submissions. This report and its recommendations address these concerns, and, in effect, provide a 'how to' manual that will lead to better quality service for Ontario's home care clients and their families.

The review makes its recommendations in the context of a competitive service delivery model. We assessed a number of procurement models during the course of our review, and have selected the best elements from a variety of these models to design a procurement solution specifically made for Ontario.

The CCAC Procurement Review completed its work on a tight, six-month time line. During that time, the Procurement Review traveled the province, meeting with over 200 groups and organizations. The Review received over 80 submissions and 50 letters. In addition, the Procurement Review commissioned research among home care clients, home care workers and the general public.

Getting to the quality goal

Better quality home care is a shared goal, and developing recommendations that will ensure that we reach this goal, is the primary focus of this Report.

Through better quality care, home care will achieve better client service. Quality will improve continuously as benchmarking and best practices are employed, as changes are implemented that will stabilize the workforce, as more consistency of care is available, and as services are streamlined.

The same initiatives and reforms that will result in better client service will also result, if implemented, in greater value for taxpayer's money. The best quality care and the most effective use of funds are not mutually exclusive concepts. They are complementary and mutually reinforcing.

Current challenges

The biggest challenge facing home care is that there is a clear need for consistent, accessible information that can provide a basis to measure client outcomes, disseminate research and best practices and report on overall home care performance. Stakeholders across Ontario would like to see streamlined processes, increased consistency and greater transparency for all procurement practices.

Ensuring continuity of care, in all its forms, was a challenge identified by providers, workers and clients alike. Many expressed a desire to see more stability in the sector and greater attention to worker and client satisfaction.

A major challenge addressed by the Procurement Review was the misalignment of incentives to foster innovation and encourage cooperation in home care.

Highlights

The CCAC Procurement Review makes 70 recommendations, which will allow home care to realize its potential in the best interests of clients and their families.

The most important recommendation, from which all else flows, is the need to establish the Centre for Quality and Research in Home Care (CQR). Accurate information is the foundation on which to build a home care sector that is focused on continuous improvement, innovation, and best practices, all of which must be aimed at the ultimate goals: client and family satisfaction. The CQR would collect consistent information and set key performance indicators with a view to providing more effective, higher quality service to home care clients. Other key recommendations would:

- Implement a province-wide, one-stop certification process to replace the current patchwork of pre-qualification requirements.
- Allow for longer-term contracts for those providers who demonstrate excellence in service to clients.
- Change the way care agencies are paid, from "fee for service" or "per visit" to "fee for client." In other words, establish a client-focused envelope of funding so care is delivered based on real client needs rather than the number of visits made.
- Provide more choice, more flexibility, more and better information for clients and their families about their care options and rights.
- Establish ways to standardize and collect better information for the use of service providers and CCACs to measure progress, improvements and success in the home care sector.
- Obtain better value for money in the procurement of medical equipment and supplies.
- Make home care a priority for the Government's Information Technology and Transformation agenda.
- Protect and enhance workers rights. A satisfied workforce leads to better quality service for clients and part of delivering satisfaction comes from delivering choice. Workers want choice. Part-time casual and full-time work should both be encouraged and seen as valid employment practices, and all employees should benefit from the protections of the Employment Standards Act.
- Clarify the roles and responsibilities of the Ministry of Health and Long-Term Care, CCACs, Case Managers and Boards of Governors.

Cost-effective and *health-effective* choices

It is of concern that home care funding has been declining as a percentage of total health care spending over the past few years. The Procurement Review commends the McGuinty Government's commitment to reverse this trend by allocating new investment in the sector beginning in 2003/2004.

Home care must be viewed in the context of, not in isolation from, the hospital sector. Ontarians deserve a seamless continuum of care, when needed, as close to home as possible. Effective home care is a key element in the ongoing transformation to a more community-based system of care.

It is both more cost-effective, and more *health-effective*, to provide appropriate care in the home. Studies show that people get better faster at home. People are generally happier, and recover faster both physically and mentally at home.

The CCAC Procurement Review believes that implementing the recommendations in this report will transform home care to enable more people to remain in their homes and communities. The review's recommendations can be implemented at moderate cost over the next three years (see timeline for implementation of recommendations on page 68). Implementing the Review's recommendations can - and should - play a significant role in realizing the potential of home care in Ontario.

Summary of Recommendations

Quality, Benchmarks, Best Practices and Accountability

Recommendation 1: Establish a Centre For Quality and Research in Home Care (CQR) to lead the necessary research to inform good policy in home care. The Centre to report on client outcomes, establish benchmarks, disseminate best practices, encourage innovation and promote excellence in home care.

Recommendation 2: Streamline multiple pre-qualification processes by creating a one-stop, province-wide pre-qualification/certification process. The CQR to develop a comprehensive certification model based on objective criteria. All providers to be certified by discipline and by volume. In the interim, province-wide pre-qualification to be administered by the OACCAC and supported by CCAC expertise.

Recommendation 3: Give the OACCAC the mandate to develop consistent tools for contract monitoring. Contract monitoring also to be enhanced by creating an internal system auditor within the OACCAC.

Recommendation 4: The OACCAC to lead a task force of stakeholder associations, including representatives with expertise in performance measurement to complete current work on establishing common key performance indicators and the relevant common definitions. This to be included in the standards and services schedule of the RFP. In the longer term, this work to be done in consultation with the CQR.

Stability and Rewarding Results

Recommendation 5: Increase stability in the workforce with longer-term contracts for those who meet established criteria for excellence in home care.

Recommendation 6: Create incentives for excellence by establishing a Preferred Provider designation for agencies with good employment practices and demonstrated excellence in service to clients. The CQR to ensure good employment practices are defined through consultation with human resource experts and relevant stakeholders.

Recommendation 7: The OACCAC, in consultation with service providers, to develop a consistent set of principles for establishing the number of service providers for projected volumes.

Client Choice and Client Outcomes

Recommendation 8: Improve communication of client rights to ensure they are aware of their options in home care, including the right to request a review of their case through the Health Services Appeal and Review Board, or the Provincial Ombudsman without consequence.

Recommendation 9: Give clients who are dissatisfied with their care a choice. When a client consistently expresses dissatisfaction with care, service providers will be asked to change the caregiver. If dissatisfaction with care continues, case managers will offer clients a choice of other available service providers.

Recommendation 10: The OACCAC to lead the development of consistent client survey tools for use by CCACs and service providers, with independent analysis, and allocate points for client survey results in the RFP evaluation.

Recommendation 11: Expand the Provincial (LHIN) 'Long-Term Care Action Line" to include home care client, caregiver and service provider concerns. The Action Line to provide a forum to hear confidential concerns. Clients to be given phone numbers for the service provider, case manager and the provincial (LHIN) action line to report concerns.

Recommendation 12: Service providers to improve continuity by ensuring better communication between all workers providing care to individual clients.

Recommendation 13: Enhance continuity of care by requiring transition planning, both entering and exiting a contract, and ensuring better communication to clients and home care workers.

Recommendation 14: Give end-of-life clients, children and vulnerable clients special consideration during contract transitions.

Recommendation 15: CCACs to partner with hospitals to coordinate inpatients, emergency and outpatient discharge planning. The hospital and the CCAC to share funding for these services.

A More Satisfied Workforce

Recommendation 16: Reward excellent employment practices of service providers with additional points in the RFP evaluation process once Preferred Provider status is achieved.

Recommendation 17: The OACCAC and service provider associations to consider setting basic employment standards for the industry, including dental, drug plans, pension and mileage.

Recommendation 18: As new contracts are awarded, eliminate elect-to-work as described in the Employment Standards Act in home care so that all workers receive full coverage under the Employment Standards Act related to paid statutory holidays, notice of termination and severance pay.

Recommendation 19: The OACCAC to establish a steering committee with provider associations and the Ontario Hospital Association to begin necessary planning for the elimination of elect-to-work.

Recommendation 20: Remove barriers to entering the home care workforce. CCACs not to require 100% PSW status within the procurement process. Employers to commit to training and supervision of personal support workers until they achieve PSW status, generally within two years from the date of hire.

Recommendation 21: MOHLTC and Ministry of Colleges and Universities to evaluate PSW training programs. The evaluation to include both length and content of the curriculum, and be completed before any changes are permitted or funded.

Better Procurement Practices: Enhancing Consistency and Transparency

Recommendation 22: Revise the scoring system for quality evaluation and have the written document, the interview and the site visit be of equal value.

Recommendation 23: Develop consistent evaluation tools based on objective criteria for the RFP written document, interview and site visit. Site visits to be mandatory for eligible bidders (those bidders that have passed the written document and interview stage at a score of 75%). Evaluation tools to include modules that take into account large/small, urban/rural regional differences.

Recommendation 24: Include a disclaimer in the RFP to make it known that as an agent of the government, CCACs are subject to PIPEDA and the Freedom of Information and Protection of Privacy Act which means all information under the care and control of CCACs may be subject to disclosure.

Recommendation 25: Develop common briefing and debriefing tools so that CCACs provide all bidders and subcontractors with common information. As part of the debriefing, the price of the winning bid to be made public.

Recommendation 26: CCACs to clearly specify the local issues that need to be addressed in the procurement process. CCACs to evaluate service providers on local issues only where these issues clearly have an impact on service delivery.

Recommendation 27: The composition of evaluation teams to be consistent across CCACs. All teams to be composed of 5-7 members with at least one member from the Community.

Recommendation 28: The OACCAC to develop common survey tools for stakeholders to evaluate CCACs. The survey of CCACs to be an anonymous annual survey of stakeholders including contracted service providers, clients, community organizations and hospitals.

Getting Value for Money

Recommendation 29: Until such time as the CQR introduces a value for money or new pricing formula, all CCACs to use a common formula for price evaluation that best reflects pricing differentials.

Recommendation 30: The CQR to evaluate new pricing formulae to address current concerns, including a value for money formula for those who pass a quality threshold of at least 75%. The score to be calculated as follows:

$$\frac{\text{Price} - \text{estimated severance}}{\text{Quality}} \times 100 = \text{Value for Money Index}$$

Recommendation 31: Conduct information interviews for high bids (15% above the highest bid) and sustainability interviews for low bids (15% below the median). The sustainability interview to determine whether the service provider should be disqualified. This applies only to those service providers that have been identified as being eligible for a contract.

Recommendation 32: Implement the Ontario Provincial Auditor's recommendation to move toward a funding formula based on need by shifting to client-focused envelope funding. Begin demonstration project with eight CCACs, with the goal of expanding the alternative funding model to all CCACs by 2010.

Strengthening Not-For-Profit and Low Volume Providers

Recommendation 33: The Government to build capacity in quality management in agencies receiving direct government funding for CSS through the creation of training and educational opportunities.

Recommendation 34: In the event of a tied score (quality and price scores are equal), and the incumbent is not part of the tie, service providers receiving direct government funding for Community Support Services to receive preference.

Recommendation 35: Amend the RFP and RFQ so that there is no requirement for service providers to create a new legal entity if they wish to enter into joint ventures, consortia and partnerships. CCAC approval to be sufficient for sub-contracting.

Recommendation 36: Allocate up to 15% of total service volumes to small-streams to facilitate contracts for low-volume and niche providers, and to encourage new entrants to the market.

Recommendation 37: Develop a simplified RFP to meet the needs of small-volume providers.

Stimulating Innovation

Recommendation 38: Give CCACs more flexibility to encourage innovation by increasing the current exemption from RFP from $150,000 to $250,000 per contract per year. CCAC boards to approve all RFP exemptions and also notify the CQR of innovations funded in this manner.

Recommendation 39: Allow CCACs to re-profile up to 5% of their budget annually. This 5% to be directed to a reserve fund to balance future budgets or be used for one-time expenditures.

Recommendation 40: Give service providers credit in the RFP for innovations that improved efficiency and effectiveness. CQR to widely disseminate information about innovations developed in financial partnership with the CQR or a CCAC.

Medical Supplies and Equipment

Recommendation 41: Develop a common procurement contract template for medical/surgical supplies and equipment. Use template in cases where there is a significant service component. Use a tender process where there is no significant service component.

Recommendation 42: Evaluation of an RFP for selected supplies and equipment to be based on a 25% score for quality and 75% for price.

Recommendation 43: OACCAC be mandated to establish a stakeholder committee including representatives from the College of Pharmacy, the College of Nurses, and infection control experts to review procurement of infusion therapies and to develop standards. Evaluation of infusion therapy providers to be based on quality pharmaceutical standards.

Recommendation 44: Enhance consistency of procurement through standardization, improved contract monitoring, consistent polices, and the development of consistent electronic ordering and billing procedures.

Recommendation 45: Expand group purchasing initiatives to include major cost items common to all CCACs and LHINs, where appropriate.

Creating a Home Care System using Information Technology

Recommendation 46: Declare home care a top priority for IT investment by MOHLTC through the eHealth Council and it's sub committee, the Continuing Care eHealth Council, including the Smart Systems for Health Agency. Within home care the focus to be on electronic referrals from CCACs to community providers, common assessment of client need and an application that captures and stores the client's history and is a building block of the electronic health record. If priority status is not granted, allow the OACCAC and the CCACs to proceed in alignment with eHealth Strategies.

Recommendation 47: Coordinate home care with other Government IT initiatives and assign IT Project Management functions for CCACs to Smart Systems for Health and its Deployment Planning and Management Office. If priority status is not granted, allow the OACCAC and the CCACs to proceed in alignment with eHealth strategies.

Recommendation 48: Consider expansion of the Waterloo Region CHIN and/or other information sharing systems to all CCACs, as part of the consolidation of CCACs.

Recommendation 49: OACCAC to define data standards and nomenclature immediately to ensure easy sharing, consolidation and comparison of data and this should be aligned as appropriate with the work of the Ontario Health Information Standards Council.

Transfer of Children's School Program

Recommendation 50: MCYS to conduct a review of the School Health Support Services program currently funded by the MOHLTC and delivered by the CCACs to develop a long-term strategy for both the co-ordination of services to children in schools and the funding of these services. The review to involve the MOEd, MOHLTC, MCSS and agencies currently delivering home care school programs.

Role of the Ministry of Health and Long Term Care

Recommendation 51: MOHLTC to monitor compliance with the Long Term Care Act and maintain accurate information on wait lists on both acute and chronic clients in need of home care.

Recommendation 52: The MOHLTC to monitor who is receiving home care services and who is not receiving services, including acute and chronic maintenance clients. Develop and implement appropriate regulations to support this function.

Recommendation 53: MOHLTC to establish a Committee with representatives from the OACCAC and the proposed CQR to develop new funding approaches for the home care sector based on demographics and need. This Committee to be supported by senior MOHLTC officials.

Recommendation 54: MOHLTC to place a high priority on completing the revised Home Care Policy and Procedure Manual.

Recommendation 55: MOHLTC to provide orientation and ongoing training and education for modern board governance.

Building Better Boards

Recommendation 56: Strengthen board experience by having at least one member who has extensive knowledge and experience in procurement.

Recommendation 57: CCAC boards to receive regular reports from staff on contract monitoring and preferred providers. In keeping with recommendation 7, Boards to oversee that agreed upon volume principles are followed.

Recommendation 58: MOHLTC to consider cross-appointments between CCAC and LHIN boards.

Recommendation 59: CCAC boards to monitor and reduce administrative costs (including administrative costs related to case management) wherever possible. The case management service to be reported as a line item in the budget.

Promoting a Quality Culture at CCACs

Recommendation 60: CCACs to be accredited by an appropriate organization within five years. MOHLTC to determine which accreditation is most suitable for CCACs, and whether modifications are needed.

Recommendation 61: All CCACs be required to participate in the Progressive Excellence Program of the National Quality Institute.

Recommendation 62: The CCAC mandate to be amended to remove provision of 'direct' services. Direct services include nursing, personal support, homemaking, and therapies. This change is recommended in order to avoid a conflict of interest between the CCACs role as gatekeeper of government funding and decision-maker on quantity and nature of services to be provided.

Recommendation 63: CCACs to be prohibited from hiring staff from a service provider who holds a current contract in the region until the existing contract has ended or providers are compensated.

Recommendation 64: CCACs to implement an annual communication plan that promotes who they are, what they do and how to access home care services. All CCACs to publicly release reasons why the winning bidder was chosen and reasons why the unsuccessful bids were rejected without prior approval from the MOHLTC.

Recommendation 65: Strengthen dispute resolution mechanisms. All contracts to include agreement that material issues, excluding renewal, be resolved by mediation or, if necessary, by arbitration.

Clarifying the Role of the Case Manager

Recommendation 66: The OACCAC to consult with the MOHLTC and a broad range of stakeholders to obtain feedback about new definitions of the role of case management, including system navigation and/or disease management strategies.

Leadership Role for the OACCAC

Recommendation 67: The OACCAC be given the necessary authority by a memorandum of understanding with the MOHLTC to carry out its enhanced role. CCAC participation in the OACCAC should be mandatory. The OACCAC mandate as advocates for CCAC'S should be diminished as they assume a greater stewardship responsibility.

Recommendation 68: The OACCAC Board of Directors should include at least 1/3 community membership in addition to CCAC members.

Recommendation 69: Starting with the oldest contracts first, the OACCAC to develop a staggered roll out plan for the resumption of RFPs beginning in April 2006. Further, a transparent procurement cycle to be developed for each CCAC and coordinated within the LHINs.

Recommendation 70: All contracts let under the 2003 RFP template to be eligible for a 3-year renewal upon expiration of existing contracts and for Preferred Provider status.

Introduction

Purpose of the CCAC Procurement Review

The McGuinty Government established the CCAC Procurement Review on October 4, 2004 to undertake a review of the competitive bidding process used by Community Care Access Centres (CCACs) in Ontario to select providers of goods and services.

The mandate of the CCAC Procurement Review is to assess:

- Are clients getting best quality?
- Are taxpayers getting good value from home care services?
- What is the impact of the current method of sourcing and delivering home care on the quality and price of service delivered to clients?
- Can the method of sourcing and delivering home care be improved to support quality, continuity of care and greater stability in the workforce?
- Are the resources required by the CCACs and service providers reasonable for the administration of the current policy, procedures and standard template documents?
- Can mechanisms be enhanced for continually improving the method of selecting service providers?
- Is the Ministry of Health and Long-Term Care (MOHLTC) effective in supporting the procurement and delivery of home care policy?
- Are there any other recommendations that should be considered related to the scope of the Review?

The Procurement Review has not made recommendations regarding the conduct of individual CCACs, or individual procurement decisions.

Recommendations relate to the procurement process, including the Request for Proposal (RFP) template, quality, workforce stability, and price issues.

(A) Home Care: Part of the move to community-based care

The Procurement Review was pleased to see that the Government of Ontario is committed to providing more community-based care. Better and more effective home care will allow people to be cared for and remain longer in their homes. It also is especially important as people are being released from hospital into the community earlier, and with a greater need for support. New technologies, such as home infusion, mean that caregivers are caring for increasingly acute individuals at home. As the population continues to age, more people will be using home care services. It is important to get the system working well now, so it can meet these increasing demands.

A common definition of home care is difficult to delineate. There is considerable variability in who might receive care and what services they might receive. Home and community services can substitute for acute care in hospitals and/or provide services to post-acute patients who have been discharged from hospital. They can substitute for services provided by long term care homes. They also can represent an appropriate way of maintaining health and allowing clients to remain independent for a longer period of time, thus avoiding or

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Recommendations relate to the procurement process, including the Request for Proposal (RFP) template, quality, workforce stability, and price issues.

(A) Home Care: Part of the move to community-based care

The Procurement Review was pleased to see that the Government of Ontario is committed to providing more community-based care. Better and more effective home care will allow people to be cared for and remain longer in their homes. It also is especially important as people are being released from hospital into the community earlier, and with a greater need for support. New technologies, such as home infusion, mean that caregivers are caring for increasingly acute individuals at home. As the population continues to age, more people will be using home care services. It is important to get the system working well now, so it can meet these increasing demands.

A common definition of home care is difficult to delineate. There is considerable variability in who might receive care and what services they might receive. Home and community services can substitute for acute care in hospitals and/or provide services to post-acute patients who have been discharged from hospital. They can substitute for services provided by long term care homes. They also can represent an appropriate way of maintaining health and allowing clients to remain independent for a longer period of time, thus avoiding or

delaying the need for institutional care. Finally, they can prevent deterioration through additional services and monitoring. The mix of clients, services, and service providers vary accordingly.[1]

A variety of professionals provide services to home care clients including registered nurses, registered practical nurses, physiotherapists, occupational therapists, social workers, dieticians, and speech-language pathologists. In addition, unregulated personal support workers (PSWs), homemakers and attendant care workers all provide personal support services to clients.

On July 6, 2004, the Honourable George Smitherman, Minister of Health and Long-Term Care said, "...for many people and for many families, health care provided in the home is the best care. [Home care] is about keeping people in their homes and communities as much as possible. It is about helping Ontarians live as independently as they can for as long as they can."[2]

People generally want to recover in the comfort of their own homes. In an Environics Survey, seven out of ten Canadians said that, if given the choice for them or a loved one, they would prefer early discharge from hospital followed by the provision of home care. Seven out of ten also say that when they cannot live any longer at home totally independently, it would be better to be at home with supports such as nursing, homemaking, and transportation rather than in an institution.[3]

The Procurement Review commissioned a survey that was conducted by Pollara Strategic Public Opinion and Market Research entitled, CCAC Procurement Review Quantitative Survey Results (Pollara Survey). An overwhelming 88% of Ontarians surveyed indicated a preference for home care for them, and 84% preferring home care for a loved one.[4]

Work by the National Evaluation of the Cost-Effectiveness of Home Care project shows that, with proper support, people can be monitored and cared for in their homes. This work provides solid evidence that investing in home-based care can save money, improve care and improve quality of life for people who would otherwise be hospitalized or institutionalized. Using data from British Columbia, care in the home was found to be 25% to 60% less expensive than the costs of facility care.[5] This means that even if the proportion of home care expenditures increase, home care continues to give the taxpayers good value for money.

Both the federal and provincial governments identified home care as a key element of the health care system. Roy Romanow, in his landmark report on the Future of Health Care In Canada, calls home care the "next essential service." The First Ministers agreed in their Federal-Provincial Health Accord (2004) that "services provided in the home can be more appropriate and less expensive (i.e. more cost-effective) than acute hospital care." They also pointed out that "home and community care services can reduce wait times for acute hospital beds, can provide choices for end-of-life care, and mental health patients."

The First Ministers also agreed in the Federal-Provincial Health Accord to provide for certain home care services, based on assessed need. These specific home care services include:

- short-term acute home care for two-week provision of case management, intravenous medications related to the discharge diagnosis, nursing and personal care;
- short-term acute community mental health home care for two-week provision of case management and crisis response services; and
- end-of-life care including case management, nursing, palliative-specific pharmaceuticals and personal care.[6]

(B) Overview of home care service delivery and funding

Home care currently serves approximately 432,000 Ontarians annually[7], and provides over 23 million units of service to clients. The largest category by far is personal support, followed by nursing (see table 1).

In 2003, the MOHLTC introduced a requirement for CCACs to categorize home care clients by service recipient code based on standard MIS definitions. These service recipient categories provide information on the type of home care services being provided to clients.

The Procurement Review also received third-quarter data for 2004/2005 on service recipients by category. Data for other years is not yet available and there are continuing concerns about data quality. Collection of this data is an important indicator as to which category of client currently receives home care services. This data (shown in table 2) indicates that acute clients currently account for the largest proportion, just over 35%, of those clients receiving home care. This may in part be a result of the Federal government's targeting of federal funding for home care towards serving acute clients.

The review is concerned that without additional support for maintenance clients, a trend towards serving more acute clients may come at the expense of maintenance clients. For example, a study in the Journal of Aging and Society reports "people in need of long term personal care and practical support are given lower priority and are gradually being rationed out of the system for all but the most minimal bodily maintenance. This medicalisation of home care generates particular jeopardies for the frail older people who dominate this category of need, most of whom are women."[8] Continued collection and monitoring of this type of data will help to ensure that home care resources allocated to supporting acute clients, maintenance and long-term supportive care clients are in balance.

Home care funding had been held constant since 2000/2001. The Procurement Review also noted that funding for CCACs has declined as a percentage of total health expenditure, from 4.8% in 1999/2000 to 4.2% in 2004/2005. At the same time, funding for institutional long-term care facilities increased by 78% and funding for hospitals grew by 51%. Funding for home care as a whole did increase by 22%, but this increase is significantly below the increase in the institutional sector. At $1.3 billion, the home care sector continues to be a very small component of the overall health care budget (Table 3).

TABLE 1: Number of Service Units by Type, 2003

Service Description	# of Clients	# of Service Units
Homemaking/Personal Support	194,084	15,633,667
Nursing	223,963	6,519,692
Physiotherapy	85,911	482,648
Occupational Therapy	102,374	485,326
Social work	13,250	80,388
Speech/Language Pathology	31,423	229,104
Dietetic	14,825	55,040
Total	*	23,485,865

*Note: Clients may be receiving multiple services

Source: CCAC Foundation Briefing, October 2004

TABLE 2: Service Recipient Data by Category - Interim 3rd Quarter Data for 2004/2005

Long Term Care Placement	12.7%
Acute	35.3%
Rehab	22.4%
Maintenance	12.1%
Long-term Supportive	4.2%
End of Life	3.3%
Not Yet Categorized*	9.9%

*Clients who have not yet been categorized due to insufficient information on client care needs to make an informed decision. Source: MOHLTC, CCAC Branch, Internal Figures

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TABLE 3: Annual Provincial CCAC Funding for the Last 5 Years

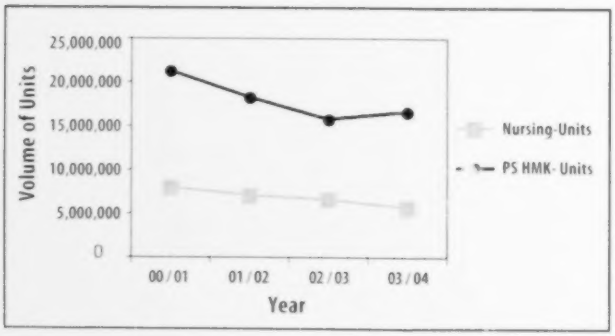
	Operating Funding to CCACs ($millions)	% Change	Operating Expenditure MOHLTC ($millions)	% of MOHLTC's Operating Expenditure to CCACs
1999-00	1,001		20,841	4.8
2000-01	1,119	11.9	22,701	4.9
2001-02	1,139	1.7	23,923	4.8
2002-03	1,168	2.6	25,800	4.5
2003-04*	1,217	4.2	28,036	4.3
2004-05 Q3	1,308	7.4	31,089	4.2

* Excludes SARS-related and major one-time costs of $824 million

Source: Ministry of Finance, Fiscal Planning Branch, Funding to Ontario's CCACs

As a result of these funding constraints and rising contract prices during this time period, the Ontario Provincial Auditor reported that the number of nursing visits in home care decreased by 22% and homemaking hours decreased by 30% from 2001/2002 to 2002/2003. The Provincial Auditor also noted that the MOHLTC had not formally assessed the impact of such a significant decrease either directly on recipients or indirectly on other parts of the health care system.[9] In addition, the Procurement Review found that the volume of units of service declined between 2000 and 2003 as shown in the Figure 1 below.

FIGURE 1: Total Service Units 2000-2004



Source: OACCAC, Financial and Statistical Overview for the Review, Dec. 2004

On a more positive note, government funding to CCACs for home care services increased in 2004/2005 to $1.3 billion (excludes Community Support Service Funding Allocation), and is expected to continue to rise to $1.7 billion in 2007/2008.[10] This begins the rebuilding of home care services. The Procurement Review encourages the government to continue in this direction. It is vital that the funding for the home care sector, as a percentage of overall health expenditure, increase faster than the acute and institutional sectors. This is necessary if the government is to achieve its goal of allowing people to remain in their homes as long as possible.

The Minister of Health and Long-Term Care continues to recognize the growing importance of home care and has dedicated more dollars for home care. In 2004/2005, there was a $103 million net increase in funding for the home care agenda for short-term acute, chronic home care and end-of-life services in the home. Starting from the base of approximately 430,000 people receiving service, an additional 21,400 new acute home care clients, 95,700 more home care clients and 6,000 more end-of-life clients will receive care in their homes by 2007/2008.[11] The Procurement Review acknowledges this trend as a very positive step and encourages it to continue.

(C) Background and context: Creation of the CCACS

Forty-three Community Care Access Centres were created in January 1996 by amalgamating 74 home care programs, placement and co-ordination centres. The number was later reduced to 42 due to restructuring. In April 1997, CCACs began selecting providers through a competitive selection process, using request for proposals (RFPs) and tendering processes.

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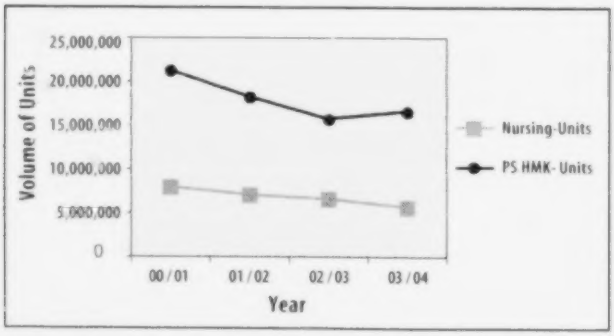

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Since their inception in 1996, a number of concerns arose regarding the consistency of governance, Ministry oversight and support, and the local operational issues of CCACs. These concerns led to CCAC reform beginning with the establishment of the Community Care Access Corporation Act in 2001.

The stated goal of creating the CCACs was to simplify access to home care, preserve existing organizations, and reduce administrative costs. The system in place prior to the creation of CCACs had been criticized for being fragmented, with inconsistent service delivery. The new system was intended to bring fairness and equitable access to services across Ontario.[12]

The CCACs were given a mandate to "ensure fair and equitable access to highest quality services at the best price."[13] They provide eligible clients with access to a range of home care services including nursing, personal support/homemaking and therapy services (such as speech therapy and occupational therapy) for adults, and for eligible children both at home and in-schools. The quantity of services provided is based on assessed need.

The MOHLTC informed the Procurement Review that funding for the CCACs is based on the historic use of services, and additional factors such as age, gender, geography/rurality and the incidence and acuity of post hospital home care clients. Therefore, not all CCACs offer the same range of services.

(D) How CCAC procurement works now

The MOHLTC revised the Client Services Procurement Policy and Procedures and the standard procurement templates for CCACs in July 2003. The procurement policy applies to the planning and acquisition of Client Services purchased by CCACs and the management of those purchased client services. It does not apply to the purchase of office supplies, equipment, consulting or financial services. Client Services includes nursing services, occupational therapy services, physiotherapy services, speech language pathology services, social work services, dietetic services, personal support services, homemaking services, as well as medical supplies and equipment. The policy states that all Client Services are to be acquired competitively through open, fair and transparent procurement processes that are consistent across the province and utilize an RFP. This procurement system is often termed managed competition.

There are some exceptions to the managed competition process in Ontario including when there are no responses from bidders to a competition and when the Ministry approves of the exception. There is also a $150,000 exemption to the RFP process for small streams and new innovative projects. Exceptions are permitted provided that it is not being done to avoid competition and where the total contract price is less than $150,000 or, where an existing contract with a service provider is terminated prior to the normal expiration date for any reason.

Medical equipment and supplies may be purchased through either an RFP or tender.

In early 2003, the OACCAC, with CCAC and MOHLTC involvement, developed a common request for proposal (RFP) template for the procurement of Client Services. The template procurement documents include a pre-qualification document, an RFP, and the template services agreement between CCACs and successful bidders. Training on the new template followed, and the new procurement process came into use during Fall 2003.

A pre-qualification of all nursing, personal support and homemaking service bidders is required, and is currently done by individual CCACs prior to the RFP process. Pre-qualification is optional for other services. CCACs are required to advertise all competitive procurement processes using an electronic tendering system and/or advertising in both local and province-wide newspapers.

In the procurement process, CCACs must identify the number and length of contracts that they are seeking. There must be a clear definition of the service requirements and performance standards to be used. As well, quality indicators, reporting requirements, monitoring, and an annual evaluation of the service provider also must be part of the contract.

CCACs evaluate providers using an evaluation committee consisting of local membership. The proposal is first evaluated based on quality, then on price. Quality is evaluated on the RFP document and interviews with bidders. Site visits are an optional component of the process.

The MOHLTC introduced the new procurement policy to improve procurement planning, provide clarification on service requirements and performance standards, allow bids to be priced based on specific volume ranges, and better evaluate quality and price. In addition, the MOHLTC had envisioned that each CCAC would submit an annual procurement report outlining the value and types of contracts awarded, a description of procurement exceptions and contract performance reports. This has not yet been implemented.

(E) Key issues for the Procurement Review

Since the introduction of managed competition, clients, home care workers, service providers, the CCACs and the public raised numerous issues regarding home care in Ontario. In particular, the way home care is procured and delivered was repeatedly identified as a concern.

The Procurement Review heard that people in Ontario want quality home care, but it determined that the information needed to measure quality is not readily available. There is an obvious need for consistent, accessible information that can provide a basis to measure client outcomes. There is currently no single authority to locate or collect this information, commission research, promote innovation, monitor client outcomes, or undertake the work needed to develop quality indicators. Work currently being done in this area is fragmented and generally conducted by individual CCACs and service providers without province-wide co-ordination. Without good information, based on reliable data, it is difficult to make informed policy decisions.

The Procurement Review also learned that there was a need to review the pricing mechanism to ensure Ontarians get the best value for money in combination with high-quality care.

Clients told the Procurement Review that continuity of care and continuity of caregiver are important to them. Clients, workers and providers said that there should be more contract stability, and better transitioning of contracts when a change does occur. Clients also want opportunities for feedback and for choice, particularly when they are not satisfied with current services.

Home care workers are concerned about feeling their work is valued, employment stability, benefits and working conditions. They would welcome measures that would take these issues into consideration. A satisfied workforce leads to better client outcomes.

Service providers told the Procurement Review that the procurement system needs to be streamlined, and processes need to be more consistent and transparent. They also indicated that they want to see consistency in evaluation and monitoring tools. Service providers want to avoid providing similar information multiple times in a slightly modified fashion.

Small service providers told the Procurement Review that they are having difficulty competing under the new procurement process. They also would like to see more opportunities for niche providers in the procurement process and in the home care market in general.

The Procurement Review also heard that the present fee-per-visit funding structure creates incentives to maximize number of visits to clients, particularly in nursing and therapies. Several stakeholders encouraged the review to examine alternative funding models that would create incentives to provide service to all clients regardless of the complexity or location of their case and place a greater focus on meeting client needs.

Finally, the linkage between home care and other sectors such as hospitals, primary care and schools is extremely important. Changes to the home care sector must also be evaluated in terms of the impact they have on other aspects of health care. The Procurement Review is sensitive to the need to avoid creating incentives to shift costs from one sector to another, and/or increase costs in other parts of the health sector.

(F) Taking the pulse: How the Procurement Review was conducted

The CCAC Procurement Review involved extensive consultations with service providers, health care workers in home care, clients receiving home care, health care researchers, unions and interested citizens of the Province of Ontario.

From October 2004 to January 2005, the Honourable Elinor Caplan traveled the province extensively, and met with 37 of 42 CCACs. Notice of her visit to most areas was advertised in the local papers to make the public aware of the CCAC Procurement Review, and to offer opportunities for interested citizens to meet privately with the Review Chair.

Round table meetings were held at the CCACs and included representatives from service providers, suppliers, unions, clients, and the CCACs. As well, private meetings were held throughout the Province and in the Toronto Review Office to hear from as many groups as possible within the allotted time frame. We consulted with unions that represent health care workers, academics and researchers, experts in quality management, associations and experts in information technology. All interested parties were invited to call or write the Procurement Review. In total, over 80 written submissions and over 50 letters were received before the February 15, 2005 submission deadline.

As mentioned previously, the Procurement Review commissioned Pollara to conduct a survey among Ontarians. The survey methodology featured a representative sample of home care clients, workers and the public to obtain their views on the home care services. A total of 1,000 members of the general public in Ontario, 500 home care clients, and 200 interviews with home care workers were completed. Three separate instruments were designed for the surveys.[14,15] The survey findings helped inform many of the Procurement Review's recommendations. The Honourable Elinor Caplan also personally spoke to many clients and family members via teleconference during February and March 2005.

The Procurement Review benefited from data collection and analysis conducted by IBM Business Consulting Services that was commissioned by the OACCAC.

The Procurement Review based its conclusions and recommendations on facts, and looked for evidence of trends reported in the media, and from stakeholders. Wherever possible, data was used to examine claims of trends in the marketplace.

The CCAC Procurement Review received extensive support and assistance from the CCAC Branch of the Ministry of Health and Long-Term Care, the Ontario Association of Community Care Access Centres (OACCAC), the Ontario Community Support Association (OCSA), the Ontario Home Care Association (OHCA) and Health Results Team. Everyone we contacted for information were pleased to assist the Procurement Review with its work, and the Review thanks them for their contributions and ideas.

(G) Managed competition at home and abroad

The theory of managed competition is to procure quality care at the best price within a competitive marketplace. The procurement Review examined a number of competitive procurement models to build on the strengths and address the challenges of the current procurement model in Ontario. The goal of this Review is to ensure that Ontario select the best competitive model, and that this model be well managed. Effective management includes responsible oversight to mitigate the adverse effects of unfettered competition that inevitably arise from imperfect market conditions.

The Procurement Review considered the experience of other jurisdictions where managed competition is in use. These included the United Kingdom, the Netherlands, New Zealand, Denmark and the United States. Managed competition was defined and applied differently in every jurisdiction, making direct comparisons with the Ontario model problematic. Nevertheless, the Review wanted to ensure that the lessons learned abroad were incorporated into its recommendations.

While the Procurement Review examined a number of procurement models, it was beyond the scope of the review to examine alternative service delivery models. Procurement models refer to the purchasing and management of services. Service delivery models refer to the provision of services. There are a number of different types of delivery models including:

- Self-provision where services are delivered by the government;
- Devolution where services are decentralized;
- Shared services where generic functions are centralized or pooled;
- Co-sourcing where several agencies jointly select a service provider; and
- Outsourcing where a third party delivers service.

Ontario currently uses an outsourcing service delivery model. There also are delivery models where clients are given funding and buy their own services.

In its examination of procurement models, the Procurement Review looked at which aspects of each model were most appropriate for which services and at which points in the contracting cycle. In studying these models, the following challenges were considered:

- Obtaining high-quality care and service;
- Ensuring value for money;
- Ensuring ongoing relevance and price competitiveness over longer term agreements and during renewal periods;
- Capturing creativity in a manner that is fair and objective; and
- Ensuring directives and policies are appropriate for the procurement models being used.

Several procurement models were examined to determine their applicability to the Ontario home care system:

1. Procurement models such as *Request for Information (RFI)* and *Requests for Expressions of Interest (RFEI)* primarily serve as focused market research tools. These models are not substitutes for a competitive process and contract award decisions are not made through responses to these procurement documents. They do, however, serve important purposes such as weighing the feasibility of proposed solutions; estimating costs; and understanding what services are available.
2. Screening procurement models such as *Request for Qualifications (RFQ) and Vendors of Record* serve to make competitive processes more manageable. The RFQ model screens out service providers that do not have the required capacity; limits the length and complexity of the procurement; fosters the development of provider alliances; and determines provider interest in the procurement.
3. Formal written requests for pricing information such as *Request for Tender (RFT)* consider only price submissions that meet stated delivery requirements and quality standards.
4. The existing procurement model, *Requests for Proposals (RFP)*, involves solicitation of proposals to supply complex products and services. Under this model, evaluation includes the quality of the service delivery approach as well as price.
5. Solutions-based "hybrid" procurement models include both a fixed price and transaction-based compensation.
6. Contestability models involve giving people information and other means to make decisions beyond the initial selection process.

The following procurement models also were considered but deemed inappropriate for the purposes of this review:

7. Design-Build-Operate-Transfer procurement models are typically employed for infrastructure type projects, not for the provision of client services.
8. Sole-Sourcing models involve a non-competitive selection process. While appropriate and sometimes necessary in certain circumstances, given the volume of services and the number of service providers available across the province, this model was not considered.
9. Common-Purpose Procurement models (public/private partnerships) are employed when the government and supplier share risks and rewards such as the realization of savings.

Criticisms of the current procurement model in Ontario state that competition can lead to a focus on profits, with lower quality of care and less cooperation among providers. In addition, some argue that the procurement process does not adequately reflect the quality and capability of a service provider to meet the required standards of care. Others argue that the current process leads to instability in the system and disruption to clients.

The Procurement Review studied other jurisdictions with more mature competitive processes than Ontario. The experience of other jurisdictions indicated that effective government oversight is essential to ensure quality, value and equitable service delivery within managed competition. We also found from their experiences that data collection and research are equally important. If data is not of sufficient quality, it is difficult to draw solid conclusions about what is working within a model and what is not working. The review of other jurisdictions identified that one potential benefit of managed competition is that it could lead to a shift from a government focus on simply providing services to a results-based, patient-focused approach to health care delivery. [16]

The Procurement Review's recommendations will underscore the importance of sufficient oversight of all procurement processes to ensure that all services covered by home care are effectively delivered.

While a review of service delivery models is outside the mandate of this review, many submissions also asked that the Procurement Review consider the publicly funded, publicly delivered model in Manitoba. The Procurement Review found that, despite the different approach to service delivery, the challenges faced by Manitoba are similar to those faced by Ontario. Some of the same concerns include: shifts from institutions to community-based care; increasing acuity and complexity of clients resulting in growing expenditures; recruitment and retention of trained staff; incorporation of in-home technology; and strengthening data and information systems for program planning and evaluation.[17]

The Review's recommendations will emphasize the importance of improving access to the information that is necessary to make well-informed decisions based on stated priorities. In addition, importance will be placed on fostering co-operation between service providers to ensure that best practices are incorporated across the province.

Consequently, the experience of other jurisdictions is used to recommend modifications to Ontario's procurement model that will increase transparency, provide better information and promote co-operation. The Procurement Review will address these issues in its recommendations.

Quality, Benchmarks, Best Practices and Accountability

Designing a procurement system that continually stimulates improvements in quality is a key goal of the CCAC Procurement Review. It is not possible to measure quality unless consistent, reliable data is available. The Procurement Review set out to determine the following:

- How does the sector measure quality?
- Do established benchmarks exist?
- How are best practices and research findings disseminated?
- How is accountability ensured within the system?

Feedback from Submissions and Consultations

(i) Introduce quality indicators and conduct research.

The Procurement Review heard that CCACs collect information using different definitions and data sources, and that there is no central repository of best practices or trends. There also are no methods for establishing best practices in the sector or sharing these findings across the province. In addition, there are no common benchmarks or targets to drive systemic quality improvement.

The Procurement Review heard that it is extremely important to have information that can accurately measure client outcomes. Measures that are collected currently tend to be input and process-oriented, rather than focused on client results. It is very important that structure, process and outcomes all be used to measure performance.

Stakeholders strongly supported the need for a central body to be responsible for collecting and disseminating relevant research and data in order to have an accurate measure of quality across the sector, and an ability to focus on client outcomes.

(ii) Pre-qualification is inconsistent and inefficient.

Service providers are frustrated because there is no mechanism to reward good performance or penalize poor performance. Furthermore, there are unexplained differences in the RFP pre-qualification requirements between the CCACs. Variation in pre-qualification has led to assertions of unfairness regarding the procurement process.

(iii) Service providers want more consistency in contract monitoring

Service Providers are concerned about lack of consistency in contract monitoring across the province. Several submissions raised the need to increase the effectiveness of contract monitoring to ensure that both service providers and CCACs are clear on their contractual responsibilities and obligations.

Key Findings

(i) There is a need for accurate data and consistent measurement, particularly of client outcomes

Although not yet in widespread use in home care, a considerable amount of research has been done to develop client-focused quality indicators dealing with both the outcomes and process of care. There are also a

TABLE 4: RAI-HC Home Care Quality Indicators (HCQI)[20]

Prevalence Quality Indicators	Failure to Improve/Incidence Quality Indicators
Inadequate meals	Bladder incontinence
Weight loss	Skin ulcers
Dehydration	ADL impairment
No medication review by MD	Impaired locomotion in home
Difficulty in locomotion	Cognitive function
ADL/rehab potential	Difficulty in communication
Falls	
Social isolation with distress	
Delirium	
Negative mood	
Disruptive/intense daily pain	
Inadequate pain control	
Neglect or abuse	
Any injuries	
No flu vaccination	
Hospitalization	

number of quality systems that could support the development of quality measurement and a culture of continuous improvement. The National Quality Institute has set out nine principles for the foundations of long-term quality in the public sector. These principles include a "factual approach to decision-making" where decisions are based upon measured data of the cause and effect mechanisms at work. To achieve accurate data, consistent measurements and the ability to monitor outcomes, home care needs a systematic approach to quality measurement that is focused on client outcomes and system results.

The new Resident Assessment Instrument for home Care (RAI-HC) is an important assessment instrument used by all CCACs to assess long stay clients. RAI-HC is a comprehensive and standardized instrument for evaluating the needs, strengths, and preferences of adult individuals living in the community.[19] The reliability and validity of the RAI-HC has been demonstrated through a series of international studies.[19] While the RAI-HC assessment is being implemented in all CCACs for long-stay clients, there currently is no effective mechanism in the MOHLTC to analyze the data, distribute findings, conduct benchmarking, and use the information to inform policy decision-making. An RAI instrument for short-stay clients is under development.

A three-year multinational research effort led by interRAI resulted in the development of a series of Home Care Quality Indicators (HCQIs) that may be derived directly from the RAI-HC (see table 4). In addition, these indicators have been risk adjusted to eliminate differences that may be related to population characteristics.

There are different outcome measures for home care that are in use in other jurisdictions. The Outcome and Assessment Information Set (OASIS) indicators provide another example of outcome-based measures. Examples of OASIS measures include: improvements in dressing; bathing; getting to and from the bathroom; improved ambulation; less confusion; less pain; the need for unplanned medical care; and inappropriate admissions to institutions. These measures can be found at the Home Health Compare web site www.medicare.gov/HHcompare, part of the Home Health Quality Initiative.

Together, these comprehensive quality indicators are important tools to immediately commence the assessment of client outcomes in Ontario.

Accountability between the MOHLTC and CCACs has been strengthened through development of a standard Memorandum of Understanding and Business Plans that include performance measures. However, the MOHLTC was unable to provide the results from measurements in the business plan due to concerns about data reliability.

There is no central authority facilitating research and quality measurement for the home care sector; nor is there currently a mechanism for promoting, validating and sharing best practices.

During the Procurement Review, many stakeholders relayed comments and stories to indicate that quality in home care had improved since 1996. A survey of CCACs conducted by IBM for the OACCAC supports this assertion. This survey found that, over the past 3 years, most CCACs felt quality had been maintained, and 41%

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felt quality had increased.[21] Others argued that quality has declined with the introduction of managed competition.

A client survey commissioned by the CCACs found that clients' overall perception of the quality of home care improved from 76.7% in 2003/2004 to 79.3% in 2004/2005.[22] In the Pollara survey of clients who have experienced home care in the past year, 73% rated the experience as excellent or good.[23]

In conclusion, the absence of key performance indicators with common definitions makes it impossible to measure quality objectively. Without accurate measurement, policy is developed in absence of the information needed to inform good decisions.

(ii) There is duplication in pre-qualification.

The Procurement Review found that the majority of the 42 CCACs have their own approach to pre-qualification. Consequently, service providers wishing to qualify in more than one region must undergo multiple processes under different rules and procedures. This has resulted in duplication across the sector and differences in results across the province.

Supreme Court decisions requiring a level playing field make it difficult to consider past performance during the RFP evaluation. The Procurement Review found that there are currently few penalties for agencies failing to live up to terms and conditions of a contract other than the abatement of volumes. Past contract compliance issues and compliance issues in one region are not taken into account in the procurement process in another region.

In its review of the CCAC system ' 2000, PriceWaterhouseCoopers noted that compliance with MOHLTC policies was inconsistent.[24] This concern continues under the new template.

(iii) Progress in use of quality indicators, but still lack of consistency in contract monitoring.

The Procurement Review was pleased to see that over the past four years, CCACs reported a marked increase in the use of quality management tools such as incident reporting, key performance indicators, including staff,

Structure of the Centre for Quality and Research

The CQR to be incorporated as a statutory corporation under the Ontario Development Corporations Act, and linked to the work of the Health Results Team-IT and the Ontario Health Quality Council. The CQR to have access to a wide range of expertise (including financial, business, clinical and legal) as well as access to relevant data sets, including the RAI-HC.

Functions of the CQR include:

- Identifying, validating and disseminating best practices;
- Setting benchmarks for the sector;
- Developing outcome-based performance indicators, such as premature or unjustifiable institutionalization;
- Commissioning research necessary for the sector and making data available for the research community;
- Monitoring international trends in home care, including a focus on innovation;
- Validating common evaluation and monitoring tools for the sector;
- Establishing market data on cost of service and overall prices;
- Publishing an annual Home Care scorecard using an outcome-based quality model (similar to the Hospital Report Card);
- Monitoring and responding to superior/inferior service provider performance;
- Certifying home care providers;
- Convening periodic review panels to make determinations on Preferred Provider Status;
- Establishing criteria for excellence in home care.

provider and client surveys. While CCACs have also made progress in building contract monitoring levers into agreements, concerns continue to be raised by service providers that there is little supervision of service providers' activities and results. Most of the participants in the consultation sessions agreed that more consistent contract monitoring was needed.

Features of Province-wide Certification within the CQR

- Certification to be simplified for small volume providers.
- The CQR to maintain a list of certified providers that would be made available to the public.
- Certification to be reviewed annually to maintain status.
- Annual reviews may include site visits.

Who Needs to Certify?

- To bid on CCAC contracts, all service providers to certify, including therapists and suppliers.
- National/provincial organizations to certify for their whole organization to maintain quality across their organization.

Criteria for Certification to Include:

- Existing pre-qualification criteria as set out in the current RFP template including experience, financial capability and litigation history.
- Evidence of worker and client satisfaction surveys.
- Evidence of good employment practices and provision of benefits.
- Past performance of providers and any previous issues with contract compliance, including failure to uphold 'transition-out' plans.
- Others as developed by the CQR.

In 2004, the Provincial Auditor reported that the MOHLTC has not developed the necessary processes for assessing the quality of service requirements specified in the procurement process and contracts. This led to a specific recommendation in their report for the MOHLTC to obtain reliable information to enable it to assess not only the cost of services being provided, but also the quality of service.[25]

The Health Results Team - Information Management (HRT-IM) has identified several information management needs within the broader health system. These are consistent with the specific needs of the home care sector and include:

- Coordination and integration of annual performance scorecards at all levels of the health system;
- Development of evidence-based standards for health care services;
- Validation of best practices in health care - specifically for integration and patient safety;
- Provision of performance measurement analyses to support the Ontario Health Quality Council;
- Rationalizion of performance measurement and improvement activities to reduce burden on providers;
- Creation of a culture of performance improvement across the health system;
- Increasing the scope of relevant performance measurement activities; and
- Involvement of partners in quality improvement initiatives.

If needed, our proposed Centre for Quality and Research in Home Care (described on page 13) could evolve to provide these needed functions as identified by the HRT-IM for the health care system.

Recommendation 1: Establish a Centre For Quality and Research in Home Care (CQR) to lead the necessary research to inform good policy in home care. The Centre to report on client outcomes, establish benchmarks, disseminate best practices, encourage innovation and promote excellence in home care.

Recommendation 2: Streamline multiple pre-qualification processes by creating a one-stop, province-wide pre-qualification/certification process. The CQR to develop a comprehensive certification model based on objective criteria. All providers to be certified by discipline and by volume. In the interim, province-wide pre-qualification to be administered by the OACCAC and supported by CCAC expertise.

Recommendation 3: Give the OACCAC the mandate to develop consistent tools for contract monitoring. Contract monitoring also to be enhanced by creating an internal system auditor within the OACCAC.

Recommendation 4: The OACCAC to lead a task force of stakeholder associations, including representative with expertise in performance measurement to complete current work on establishing common key performance indicators and the relevant common definitions. This to be included in the standards and services schedule of the RFP. In the longer term, this work to be done in consultation with the CQR.

Consequences of Poor Performance

LEVEL 1: Watchful waiting for minor compliance issues.

- CQR to monitor the service provider until the issue is resolved.

LEVEL 2: Limit ability to accept new contracts where concerns are more serious.

- CQR to place a "pause" on the ability of service providers to accept new contracts province-wide until the issue of concern is resolved.

LEVEL 3: Revoke certification status where a serious material breach of contract exists.

- CQR to revoke certification status from the service provider for a period of two years.
- The service provider does not obtain any new CCAC contracts in any region of the province during this time.
- Existing contracts, other than the contract where breach of contract occurred, are not affected.
- Volumes may be redistributed away from the service provider in the contract where the breach has occurred.

Note: All CCACs to collect consistent information and use consistent definitions for monitoring of contracts to assess contract compliance.

Stability and Rewarding Results

Another key goal of the CCAC Procurement Review is to improve stability in the home care sector, both for clients and for workers. Uncertainty increases pressure on clients, home care workers, and service providers, making it difficult for the home care sector to function optimally. While a change of provider may be necessary and, even beneficial in some cases, it needs to be well managed in all instances.

Superior performance that leads to high quality results should also be rewarded. The Procurement Review's objective is to raise the bar on quality and encourage an environment of continuous improvement by rewarding those service providers that surpass expectations.

Feedback from Submissions and Consultations

(i) Clients and workers want longer-term contracts.

Submissions from across the province highlighted stability as a major issue in home care. Workers, clients and service providers all pointed out that instability in the sector is disruptive for the provision of quality care.

When a long-standing service provider loses a major contract, it can lead to instability in the workforce. Clients consider continuity of care important, particularly during transition. Many clients said that they did not wish to lose a valued caregiver. Some clients were pleased with service from new providers; others were not. During transition, clients emphasized that good communication is especially important. Clients also stressed that they want caregivers to be well trained and have good skills.

Many workers stated that they are unwilling to be retained by an employer who may not have work for them on a consistent and long-term basis. Workers whose employers lose a contract may experience lost wages, lost benefits, and a loss of seniority. Employers said that they can't provide employees with long-term guarantees of employment due to short-term contracts. Some also said that they have difficulty with recruitment and retention because of an inability to offer job security.

(ii) Volume allocation is inconsistent.

Employers want to be rewarded for high quality performance with more predictable volumes and guaranteed minimum volumes. Most employers view higher volumes of work as a reward as it demonstrates confidence in their ability to deliver quality service.

Service providers stated that the allocation of volumes in the procurement process is inconsistent. They said that one service provider often can receive a disproportionate share of volume. Allocations and adjustments to volumes are often unexpected, and make planning difficult for service providers.

Smaller service providers advised that the volume awarded might not be large enough to make the contract viable for the company. Therapists also said that completing the RFP process is difficult for sole providers or those with volume capacity limitations.

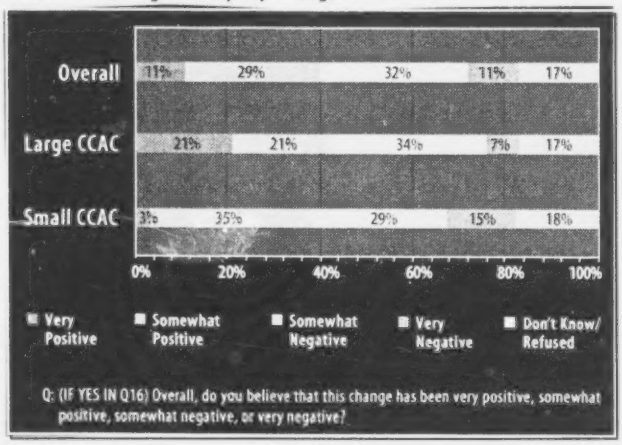
Key Findings

(i) Frequent contract transition periods are difficult.

There are several examples of excellent transitions between service provider agencies. Some CCACs established transition teams to co-ordinate all aspects of the transition process. The Procurement Review found that the frequency of transitions might be difficult for some clients. The Pollara Survey found that thirteen per cent of clients had experienced a change in the company that provided their care in the past 12 months.

Figure 2 indicates how clients perceived the transition of service providers during the course of their care. Approximately 40% of clients surveyed who experienced a change in service provider found that change to be somewhat positive, or very positive. Roughly the same percentage found change to be somewhat negative or very negative. Clients who experienced a positive change, attributed this to improvements in quality of care and improvements in staff. Those clients who had a negative perception of a change in service provider cited a range of causes including poor quality of care, a preference for previous caregivers, or the difficulty of having to get used to a new caregiver. While there was a difference in the percentage of clients rating the change as very positive, when very positive and somewhat positive were grouped, there was very little difference between large and small CCACs.

FIGURE 2: Rating of Company Change



Source: Pollara Survey[26]

While many people find change unsettling, CCACs identified three key factors that contribute to a successful transition to new caregivers for clients/families: (1) a dedicated project transition team; (2) joint client visits with both exiting and new caregiver; and (3) effective client communication.[27] The IBM Survey of CCACs identified a number of challenges to a smooth transition including:

- relying on goodwill and professionalism of outgoing caregiver and/or service provider (including receiving accurate client data);
- caregivers delaying the decision to transition to a new employer;
- outgoing workers agreeing to work for numerous other agencies; and
- the new service provider being slow to ramp up.[28]

Most CCACs developed transition plans to facilitate a change in service providers. CCACs use a number of communication channels to inform clients of an impending change. A summary of channels used by CCACs to communicate transition to clients can be found in Figure 3.

A study by Doran, Pickard, Harris, Coyte, MacRae, Lassinger and Darlington (2002) of community nursing services in Ontario found the consistency of caregiver was enhanced when longer contracts were awarded.[30] Many submissions to the Procurement Review supported this finding. For example, one group of therapists recommended that "contracts be for a longer timeframe, not include a 6-month clause for the CCAC to alter the terms of the contract, and extensions built into a signed contract be honoured unless the agency's performance standards have been unsatisfactory."[31]

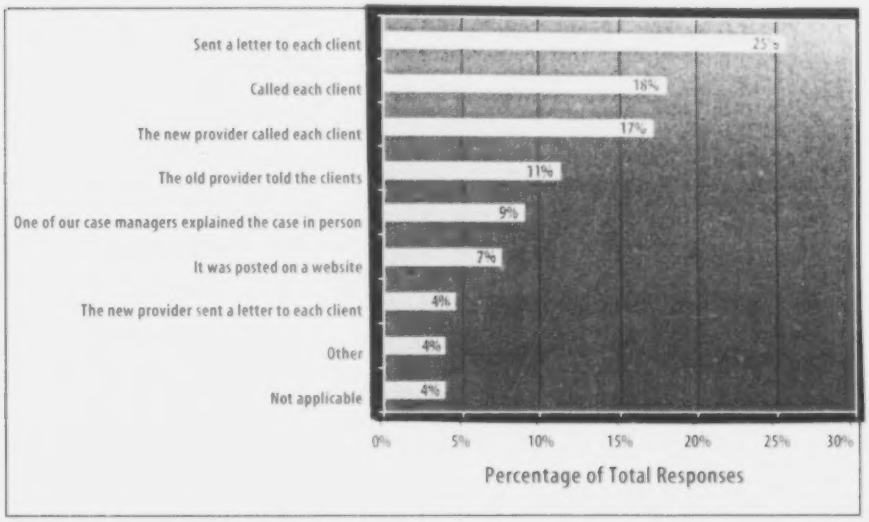
(ii) There is an absence of clear principles to allocate service volumes.

The Procurement Review did not find sufficient information on volume allocation, or the reasons behind it, to confirm provider assertions that volumes are inconsistently allocated. However, CCACs were unable to provide a consistent explanation of how volumes were distributed.

Recommendation 5: Increase stability in the workforce with longer-term contracts for those who meet established criteria for excellence in home care.

Recommendation 6: Create incentives for excellence by establishing a Preferred Provider designation for agencies with good employment practices and demonstrated excellence in service to clients. The CQR to ensure good employment practices are defined through consultation with human resource experts and relevant stakeholders.

FIGURE 3: How Clients Were Informed of a Change in Service Provider



Source: IBM Survey of CCACs[19]

Recommendation 7: The OACCAC, in consultation with service providers, to develop a consistent set of principles for establishing the number of service providers for projected volumes.

How Longer-Term Contracts Would Work

All initial contracts would be granted through the RFP process for three years, with two possible renewals.

For the first renewal (years 4-6):

- If the CCAC is satisfied that the provider has met contract requirements, the contract to be renewed for three years at a refreshed price.
- Prices refreshed based on objective price/cost criteria, through direct negotiations with the CCAC.

For the second renewal (years 7-9):

- The CQR will convene periodic review panels to assess applications and render decisions on Preferred Provider status.
- Only providers who have been granted Preferred Provider Status (for the CCAC or LHIN) are eligible for a second contract renewal.
- Preferred Providers negotiate directly with CCACs to refresh contracts to the current template and extend the contract for an additional three years (total nine years).
- Either the CCAC or Preferred Provider may choose the option to go to RFP with respect to the ending of any term or renewal term of the contract.
- After nine years all contracts must go to RFP.

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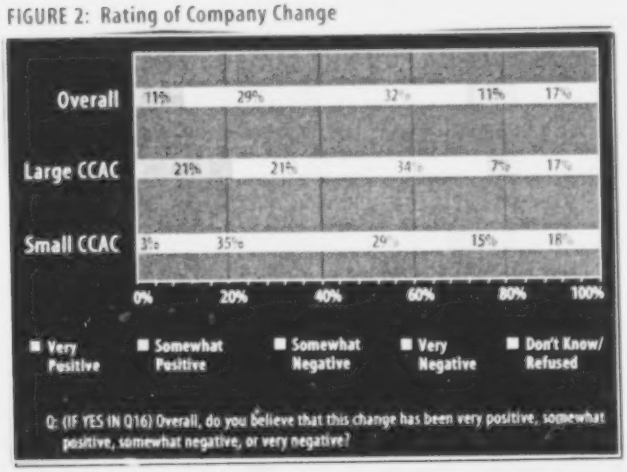

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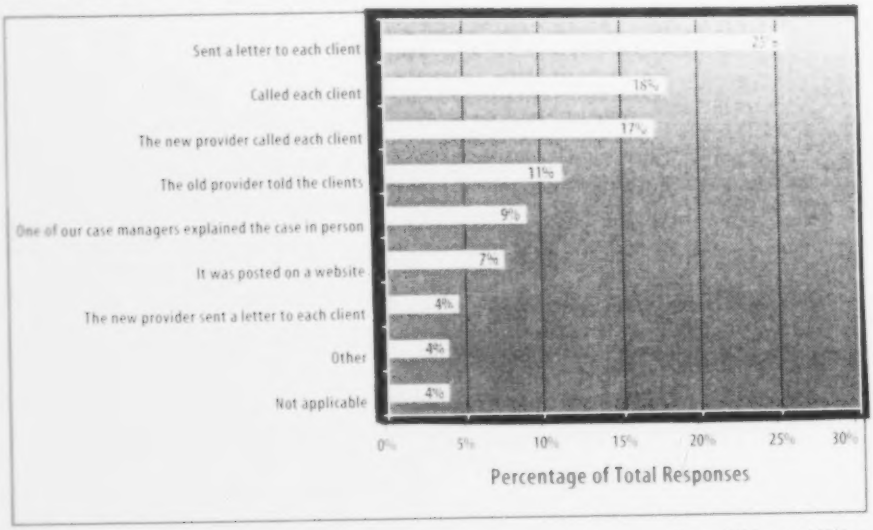

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- After nine years all contracts must go to RFP.

Preferred Providers

- All Preferred Providers to demonstrate that they have achieved excellent service to the clients and the CCACs.
- Preferred Providers to demonstrate that they are excellent employers by providing evidence of good employment practices.
- Excellent results on worker satisfaction surveys.
- Good employment practices would include appropriate spending on indirect costs and appropriate ratio of full time to part time work.

Indirect employee costs* include human resource indicators such as:

- Continuing education assistance;
- Medical, dental, or disability insurance;
- Contributions to an RRSP or pension plan;
- Quality and length of orientation;
- Education opportunities or training programs;
- Paid sick time; and
- Employee Assistance Plans.

** Not including monies spent on supervision.*

Becoming a Preferred Provider Based on Established Criteria

- Any certified service provider with five years experience in a specific region is eligible to apply to the CQR for Preferred Provider Status.
- The CQR would convene periodic review panels to assess applications and render decisions on Preferred Provider status.
- Status to be granted based on established criteria for excellence which would include but not be limited to:
- The results of client and worker satisfaction surveys;
- Client outcome information;
- Certification status;
- Implementation of best practices such as RNAO/MOHLTC Best Practice Guidelines;
- Meeting provincial benchmarks;
- Accreditation; and
- Use of quality management systems.
- Preferred status would be reviewed annually to ensure that service providers continue to meet established criteria for excellence.
- Criteria would be updated periodically by the CQR to ensure an environment of continuous improvement.

Additional Benefits for Preferred Providers

- If there are fewer service providers who respond to an RFP than the number of service providers required by that CCAC in a given region, CCACs can carry out direct price negotiations with any identified bidders and any Preferred Provider, without going to RFP.
- Additional points would be given in the RFP evaluation to service providers who have achieved Preferred Provider status in any region. This also applies to national/provincial organizations.

Safeguards

- To allow for new entrants, subcontractors and others who do not currently hold CCAC contracts, with five years experience in a specific region to be eligible to apply to the CQR for Preferred Provider status.
- The CQR has the option to set limits on market share for Preferred Providers and other service providers in each region and across the province.
- Where there are sufficient new volumes, an RFP process is required.

Client Choice and Client Outcomes

Improving client satisfaction is a major priority for the CCAC Procurement Review. The aim is to ensure that all procurement processes and procedures lead to better outcomes and experiences for clients and their families. The Procurement Review conducted extensive consultations with clients through telephone surveys, round table meetings and teleconferences.

Feedback from Submissions and Consultations

(i) Clients want to give feedback and to have choice.

Clients said that they want to be involved in planning their care whenever possible. They also want to be active participants in their recovery and help to decide how they will be maintained in the community.

When clients are not satisfied with home care, the avenues to voice complaints are limited. Complaints also need to be better tracked and recorded to ensure appropriate follow-up.

Several submissions echoed the ALS Society of Ontario's recommendation that "...because of the very real vulnerability and fear of patients and families, there needs to be an ombudsman-like, arms-length complaint and review mechanism, separate from the CCAC to review or investigate patient and family concerns and complaints in a timely, fair, accessible and transparent manner...."[32] Anecdotal reports highlighted that some clients are afraid to report their concerns about care - particularly to their case manager - for fear of losing their current services. Client advocates reported that the current formal appeals process is overly bureaucratic, lengthy and intimidating.

Most importantly, clients want to be assured that they have a qualified caregiver who is fully briefed on their case. It is especially critical during transitions between contracted provider agencies. If dissatisfaction does occur, clients want to participate in resolving the issue. Clients also expressed a desire to be able to choose an alternative caregiver if they are dissatisfied with service.

(ii) Clients want continuity of care.

Continuity means many things in home care. The Procurement Review heard about the importance of continuity in having the same person deliver care or the same service provider oversee the same team of caregivers. The continuity of care between the institutions and the community, and the continuity of service between CCACs also are viewed as extremely important.

For some, a change in their individual caregiver can be very disruptive. Many caregivers have close professional relationships with their clients, making it hard to switch caregivers. The Globe & Mail quoted Jean Wyatt, a 57-year-old Ottawa woman living with Muscular Dystrophy said that it took her a "couple of years to overcome her modesty at showering in front of a stranger, but eventually the bond was formed."[33]

Continuity issues become a focal point, especially during transitions from one service provider to another. When incumbent service providers lose their contracts, it is critical to establish and maintain good communication between CCACs, incoming and outgoing service providers, and their clients.

For vulnerable clients such as those in end-of-life situations or children, caregiver continuity is particularly important.

(iii) The basket of services offered by each CCAC is not well understood.

Hospitals, doctors and the community need to know what services CCACs offer. CCACs change services without informing hospitals, making discharge planning difficult. CCACs do not generally advertise their services.

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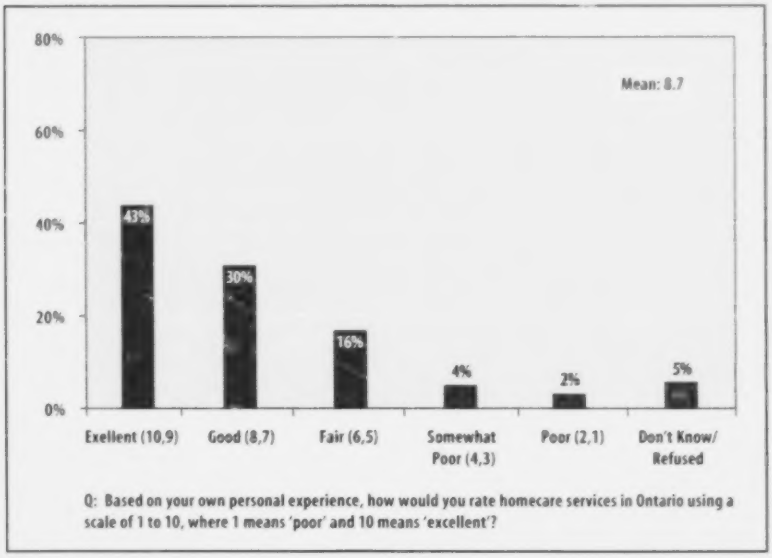
(i) There is need for continuous improvement.

CCACs generally conduct regular client satisfaction surveys, and 20 of the 42 CCACs use a common third-party survey tool. Overall, the Procurement Review found that most clients are very satisfied with the quality of home care they receive. Seven out of ten recent home care clients responding to the Pollara survey thought the quality of home care they received was excellent or good (Figure 4).

FIGURE 4: Rating of Home Care – Based on Personal Experience



Source: Pollara survey[34]

According to Figure 5, the skill and knowledge level of the caregiver, and the ability of the caregiver to communicate and connect with the client were the two highest ranked qualities of caregivers. Clients also ranked the ability to choose a service provider agency as somewhat important.

While the majority of home care clients are satisfied, 19% of respondents in the Pollara survey reported having problems/difficulties with home care services. The IBM Survey of CCACs reported that client-related incidents are relatively low on average. Over the last three years, the range was 10-12 incidents per CCAC per year for nursing; 9-12 incidents for personal support services, and 1-5 incidents for therapies.

The IBM survey also found that client complaints are generally quite low with an average of 14 complaints per 1000 visits for nursing and an average of 15 complaints per 1000 visits for therapies. For Personal Support Workers (PSWs), there were eight complaints per 1000 hours.[36] Clients said that when they had a problem with services, 32% contacted their service provider first, followed by the caregiver's supervisor 25% or CCAC 8%. Eleven per cent did not contact anyone.[37]

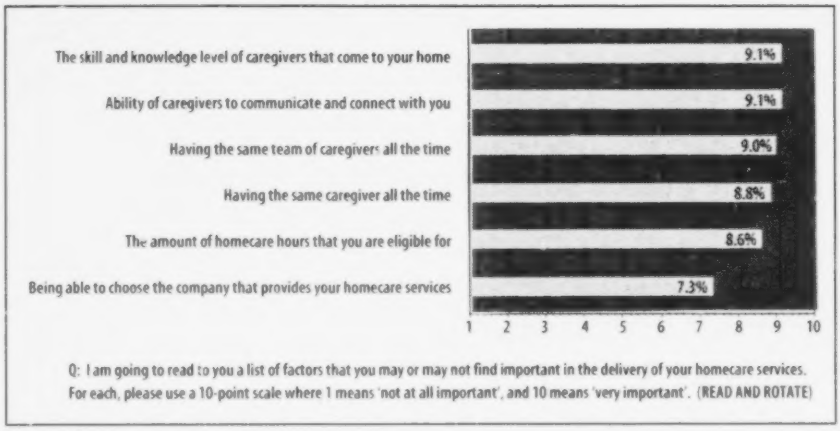
The Procurement Review found that the Health Services Appeal and Review Board is the agency that hears unresolved issues regarding the amount of service provided. MPP offices are also a valuable resource for clients seeking information and assistance regarding appeal procedures.

(ii) Continuity of care and caregiver is critical.

The Procurement Review found that clients want continuity of care and of caregiver where possible. In the Pollara survey, respondents rated having the same team of caregivers as the third most important factor in the delivery of home care. Having the same caregiver all the time ranked second in importance. According to respondents, the most

important factor in the delivery of home care is the skill and knowledge of the caregiver. (Figure 5). Teams include the case manager, and all workers providing care to the client. Team size and composition will vary according to complexity of the care plan and assessment of client need.

FIGURE 5: Importance of Delivery Factors in Home Care


The skill and knowledge level of caregivers that come to your home
9.1%
Ability of caregivers to communicate and connect with you
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Having the same team of caregivers all the time
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Having the same caregiver all the time
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The amount of homecare hours that you are eligible for
8.6%
Being able to choose the company that provides your homecare services
7.3%
1 2 3 4 5 6 7 8 9 10
Q: I am going to read to you a list of factors that you may or may not find important in the delivery of your homecare services. For each, please use a 10-point scale where 1 means 'not at all important', and 10 means 'very important'. (READ AND ROTATE)

Source: Pollara[37]

The Pollara survey also found that 57% of the home care workers surveyed had changed jobs in the past 12 months. The main reason for changing jobs was the loss of a contract by the previous company. The majority of those surveyed (87%) found that this change was positive or somewhat positive for them.[38]

The closure of a not-for-profit, unionized home support agency in Hamilton in 2002 revealed that of a total of 317 support workers who were laid off, only 38% remained employed in the home care sector.[39]

(iii) Hospital based case managers strengthen continuity.

Case managers are assigned to approximately 83% of hospital sites in Ontario, with 17% of the total number of case managers based in hospitals.[40] Twenty per cent of hospital-based CCAC case managers perform a discharge planning function for the hospital. This figure is much higher in Toronto (48%) and lowest in central Ontario (0% - 7%). When CCAC case managers are located in hospitals and work with hospital staff, it reduces duplication and facilitates continuity because the case manager can do the discharge, admission and/or referral services in one step.[41] Case managers also support Emergency Rooms to identify individuals who can receive care at home and thereby avoiding unnecessary hospitalization.

Recommendation 8: Improve communication of client rights to ensure they are aware of their options in home care, including the right to request a review of their case through the Health Services Appeal and Review Board, or the Provincial Ombudsman without consequence.

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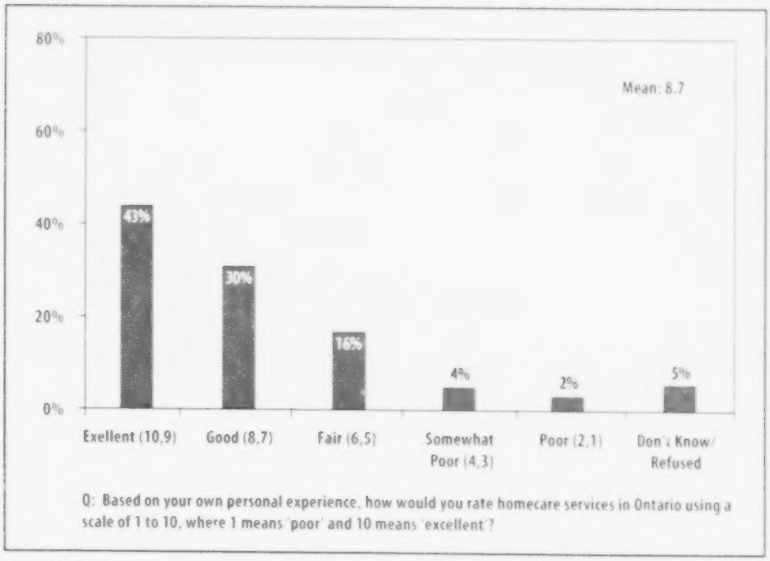

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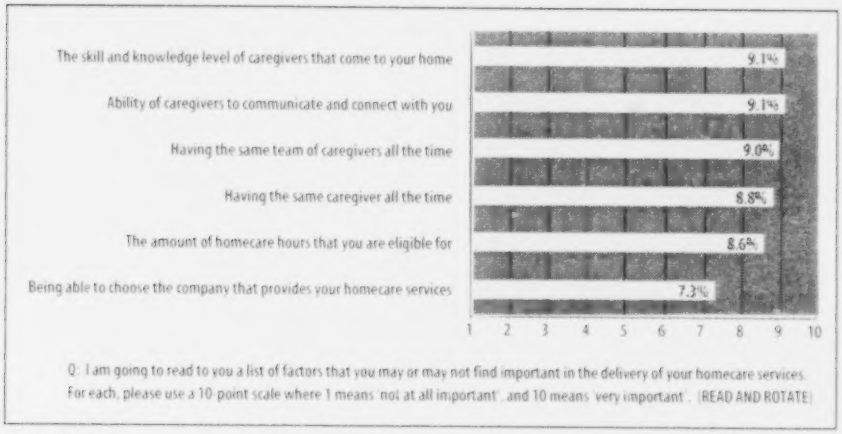
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Recommendation 14: Give end-of-life clients, children and vulnerable clients special consideration during contract transitions.

Recommendation 15: CCACs to partner with hospitals to coordinate inpatient, emergency and outpatient discharge planning. The hospital and the CCAC to share funding for these services.

Better transition planning

- As part of the procurement process, all service providers should develop and implement transition plans for both beginning a new contract and ending an existing contract. Transition plans to include specific action, timelines and accountabilities.

Better communication during transition

- CCACs to ensure that a communication plan for contract transitions is implemented successfully. All clients should be personally contacted by case managers, in writing and verbally, to increase awareness of what to expect during a transition.

Give options to clients who cannot be served to their satisfaction

- As a last resort, where a service provider is unable to provide service, the MOHLTC to consider the appropriateness of establishing a program, similar to the program in place at the Centre for Independent Living in Toronto, to allow competent clients to manage their own funding envelope and purchase their own services.
- Where a direct funding option is used, case managers to retain responsibility to monitor client outcomes and update assessment.

A More Satisfied Workforce

The CCAC Procurement Review considered working conditions and working arrangements in its examination of the procurement process. The procurement process was examined with a view to rewarding good employment practices, as well as providing the right incentives and legislative framework to improve working conditions for workers. The Procurement Review conducted extensive consultations with service providers, workers and unions. Two hundred workers also participated in telephone interviews.

Feedback from Submissions and Consultations

(i) Good employment practices should be rewarded in the procurement process.

The consultation process revealed that workers want stability, fair compensation, benefits and other non-wage compensation. Most employees said that they like helping people and caring for people, but that they are concerned about job stability and working conditions. In particular, stability is an issue during times of contract transition.

Several stakeholders claimed that, in some cases, contracts are being won at the expense of employees. For example, a service provider may come in with a lower priced bid by reducing compensation for travel time or mileage for workers.

Some service providers noted having trouble with recruitment and retention because of an inability to offer job security. The wage disparity between the home and institutional sectors also was a factor in recruitment and retention.

The lack of job security was the leading cause for concern among home care workers according to the Review survey. Forty percent of home care workers surveyed indicated that they felt not too secure or not at all secure in their jobs (Figure 6).[42] Home care workers reported that the most negative aspects of working in home care are the lack of job security, and a lack of hours (Figure 7).

(ii) The elect-to-work model may disadvantage workers and clients.

Elect-to-work is defined in the Employment Standards Act 2000 as those workers who decide without penalty whether or not to work when requested.[43] Under the Employment Standards Act 2000, there is an exemption that states:

"An employee who is employed under an arrangement where he or she may elect-to-work or not to work when requested to do so" is exempted from the requirement to be paid termination pay or severance pay under the Employment Standards Act 2000 (see Ontario Reg. 288/01 s. 2(1) 10 and s. 9(1) 9. Therefore when contracts change, these "elect-to-work" employees are not entitled to termination pay or severance pay under the Employment Standards Act, 2000.[44]

The Procurement Review heard that the elect-to-work model enables home care workers to choose their caseload. This is one reason that some workers like the elect-to-work model; it provides them with flexibility and

FIGURE 6: Feelings of Job Security

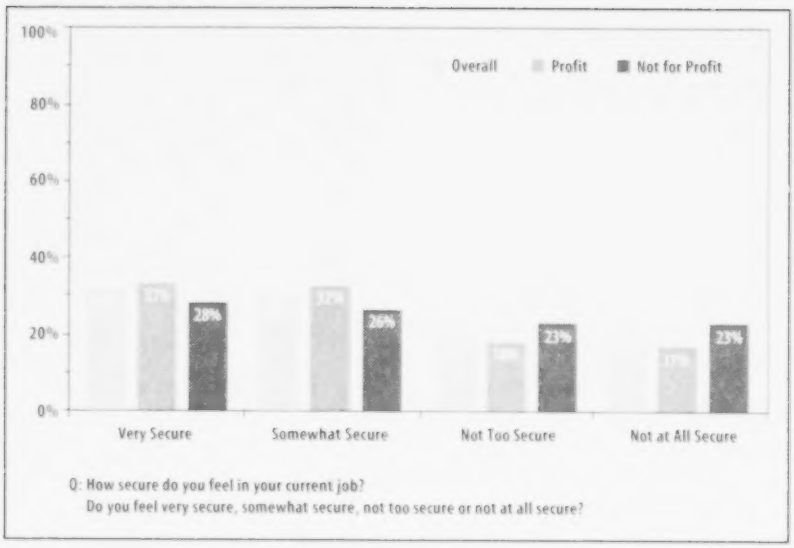
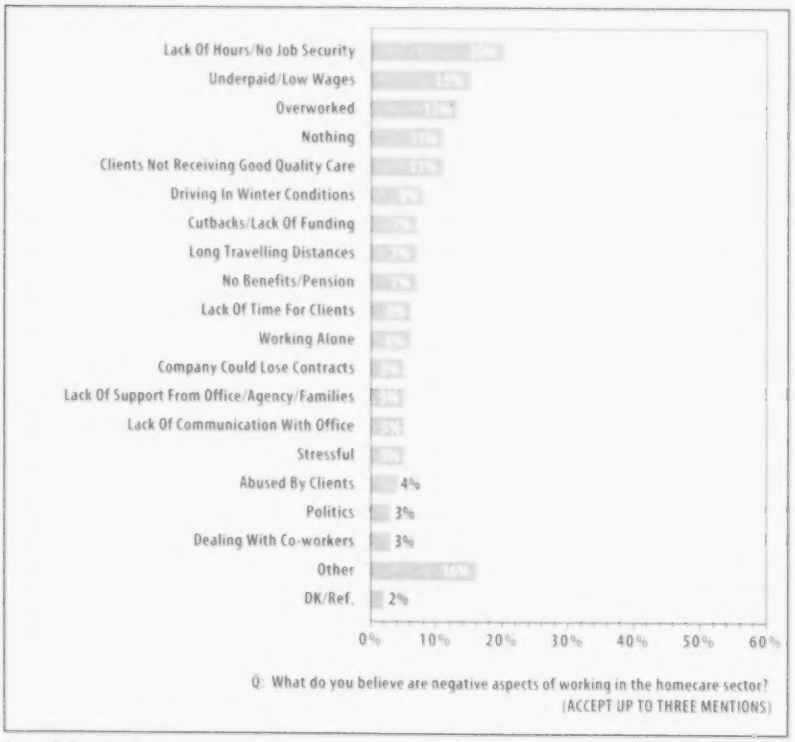


FIGURE 7: Negative Aspects of Home care Workers' Job



Source Pollara Survey

choice. However, it can lead to workers selecting cases that require less time. According to the RNAO, elect-to-work allows "nurses to skim the patients they prefer." The RNAO goes on to suggest "this results in patients with complex psychosocial needs having many different caregivers - a factor that only increases the client's burden."[45]

The Procurement Review is concerned that if this practice continues, the neediest clients will not receive necessary service.

Workers indicated that the primary benefits of elect-to-work are: ability to choose caseload; ability to establish long-term relationships with clients; ability to select desired level of work; and ability to accommodate personal needs.

Service providers told the Review that the use of elect-to-work arose in response to the "fee-per-visit" funding model used by CCACs. This funding model allows for payment only when direct care is provided. Many service providers have attempted to minimize the non-billable time for which they must pay staff by using an elect-to-work pool of staff who are prepared to offer their services as needed and on a "just in time" basis.

Service providers said that the cost of eliminating elect-to-work could be as high as a one-time cost of $62 million for severance provisions. The Procurement Review also heard that there are a number of employers who are bidding successfully and winning contracts that already include severance provisions in their winning bids. It was

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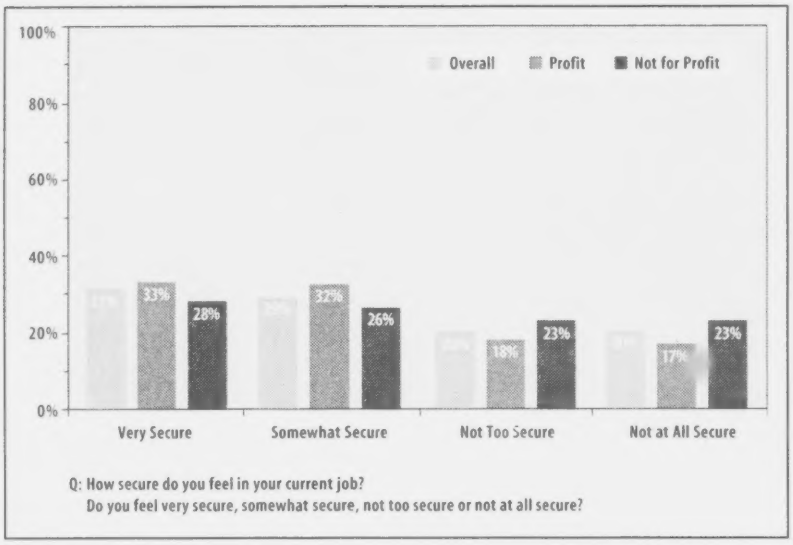

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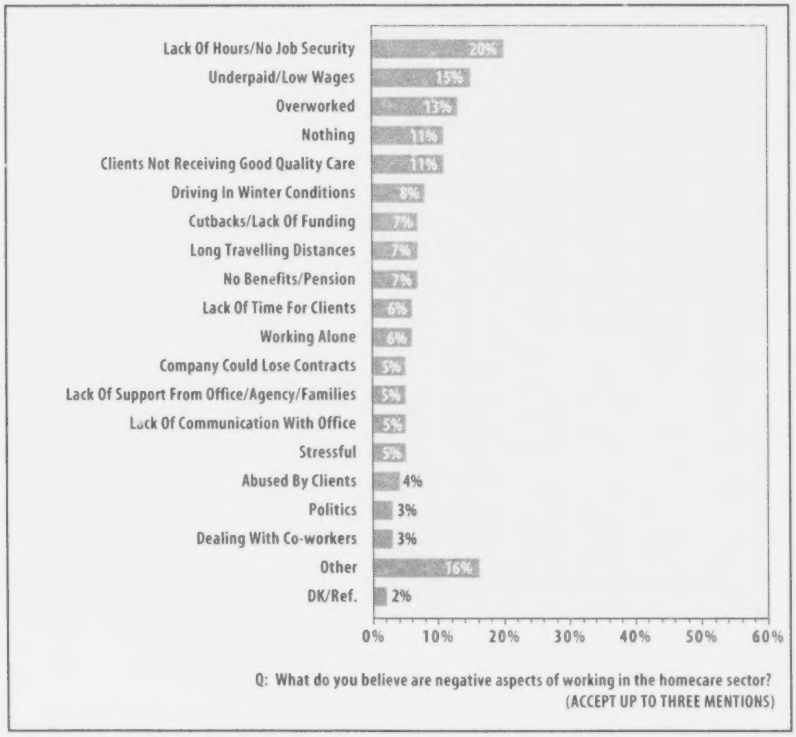
Lack Of Hours/No Job Security 20%
Underpaid/Low Wages 15%
Overworked 13%
Nothing 11%
Clients Not Receiving Good Quality Care 11%
Driving In Winter Conditions 8%
Cutbacks/Lack Of Funding 7%
Long Travelling Distances 7%
No Benefits/Pension 7%
Lack Of Time For Clients 6%
Working Alone 6%
Company Could Lose Contracts 5%
Lack Of Support From Office/Agency/Families 5%
Lack Of Communication With Office 5%
Stressful 5%
Abused By Clients 4%
Politics 3%
Dealing With Co-workers 3%
Other 16%
DK/Ref. 2%
0% 10% 20% 30% 40% 50% 60%
Q: What do you believe are negative aspects of working in the homecare sector?
(ACCEPT UP TO THREE MENTIONS)

Source Pollara Survey

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suggested to the Procurement Review that the concern appears to be the potential for reduced profits.

Some stakeholder feedback indicated that there is a cost to workers who are working under the elect-to-work model. Information obtained during the consultations indicated that the majority of PSWs who work under the elect-to-work model would like full-time or part-time status.[46] In addition, receiving severance would compensate for difficulties experienced when a contract changes. In its presentation, the Ontario Personal Support Workers Association advocated that the RFP must request full-time and part-time workers to raise the standard of care and "abolish the much abused" elect-to-work system.[47]

Submissions indicated that the elect-to-work model contributes to an unstable and unpredictable workforce, especially on weekends, evenings and holidays as many workers may choose not to work these hours. This impacts clients that have more demanding or time-consuming needs.[48]

Some submissions from PSWs and nurses stated that many workers would like more hours. From others, the Procurement Review heard that not all workers want full-time work. Meanwhile, service providers stated that moving to a requirement for more full-time workers could result in significant numbers of workers leaving the sector. Overall, it would be fair to say that, in home care, one solution does not fit all.

(iii) There are educational barriers for personal support workers (PSWs) to enter the home care workforce.

Some service providers told the Procurement Review that because of increasing CCAC expectations, they now require 100% of their PSW workforce to have completed PSW training. Workers said that in order to receive MOHLTC funding for PSW training courses, the person has to be currently employed as a home care worker. This creates a problem for workers.

The Procurement Review also heard that some educational institutions wish to increase the length of the PSW course from approximately 500 to 700 hours. Participants in the consultations said that this may not be necessary and may serve as a further barrier to entering the PSW workforce. The discussions also revealed that these programs have not been formally evaluated, and the curriculum is not consistent between training facilities.

Key Findings

(i) Employers are not rewarded for good employment practices. Majority of employees are not receiving benefits.

Numerous studies have demonstrated that an "engaged workforce is critical to organizational success." The extent to which an employee and a workforce are engaged is linked to a range of positive employee attitudes and behaviours that, in turn, influence critical organization outcomes.[49]

Review of the RFP template showed that in the assessment of the human resources plan, credit is not currently being given for providing employees with indirect benefits such as drug plans, dental care, eye care, pensions and other non-wage compensation (e.g., compensation for mileage). Furthermore, not all service providers conduct surveys of worker satisfaction. Where surveys are conducted, they are not consistent.

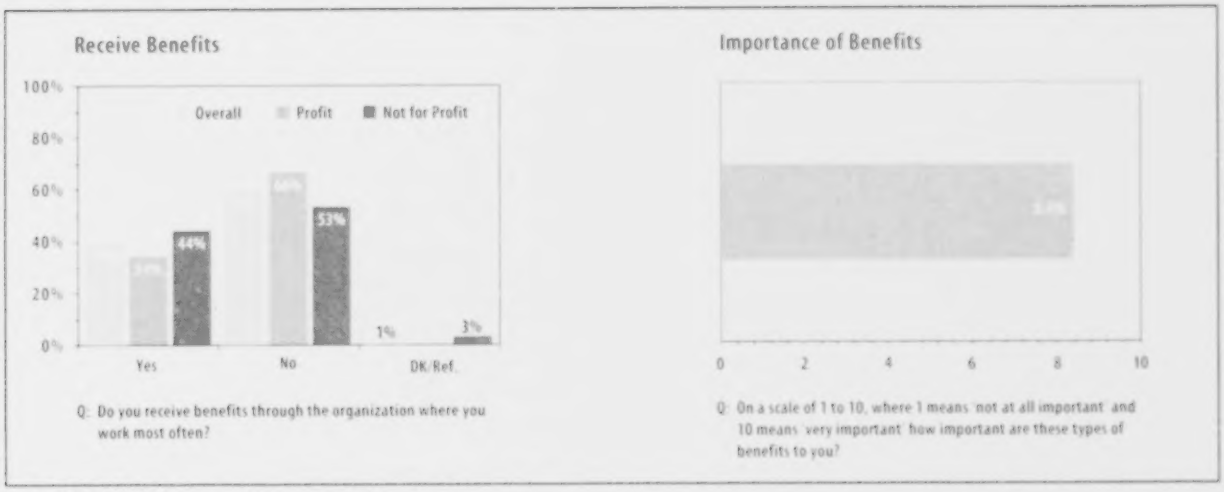
The Pollara survey of home care workers indicated that the majority of home care workers do not receive benefits even though workers consider benefits important (Figure 8).

(ii) Changes in volumes have an impact on service providers' use of elect-to-work.

Volumes of work from CCACs fluctuate which impacts staffing patterns and requirements. The OHCA estimated 36% of schedules change each week, resulting in staffing challenges. On a weekly basis, an estimated 15% of changes are caused by client turnover. A further 13 % of changes are due to client cancellation of planned service hours, unplanned discharges and reductions in service authorizations.[50]

There is a need to review how work is allocated to better match service provider capacity with CCAC demand for service. It is recognized that this review should consider

FIGURE 8: Benifits



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how to address CCAC requirements that are influenced by hospital practices and individual client demand. As elect-to-work is eliminated, consideration should be given to identification of best practices regarding continuity of care issues. The flow of referrals and the resulting impact on provider organizations should also be considered.

(iii) Moving to part-time from elect-to-work should maintain desired flexibility.

The Procurement Review found that the vast majority of PSWs work under the elect-to-work model. PSWs are the lowest-paid workers in the sector and have the least access to severance and statutory holiday pay. The MOHLTC minimum wage policy for procurement for PSWs is $9.65 per hour. In practice, the average wage for PSWs is approximately $12 per hour.[51] This minimum wage policy for PSWs is outdated and should be reviewed by the MOHLTC.

We also found that flexibility is important to workers and can be maintained through part-time work arrangements within the regular provisions of the Employment Standards Act.

(iv) The barriers to enter the PSW workforce are high.

Many employers now require that PSWs have completed their PSW training before being hired due to increasing CCAC expectations for an all PSW certified staff. This has the potential to create significant barriers to enter this occupation, which currently accounts for 67% of the volume of home care services.

Identifying Good Employment Practices

- The RFP template to request information on the results of human resource performance monitoring indicators to identify 'good employment practices.'
- Request and verify evidence of a quality management approach at the site visit.
- The RFP templates request evidence of key human resource indicators such as the percentage of total payroll dedicated to indirect costs.
- Human resource performance indicators to include information on absentee rates, attrition rates, and coverage of travel time and/or travel expenses.

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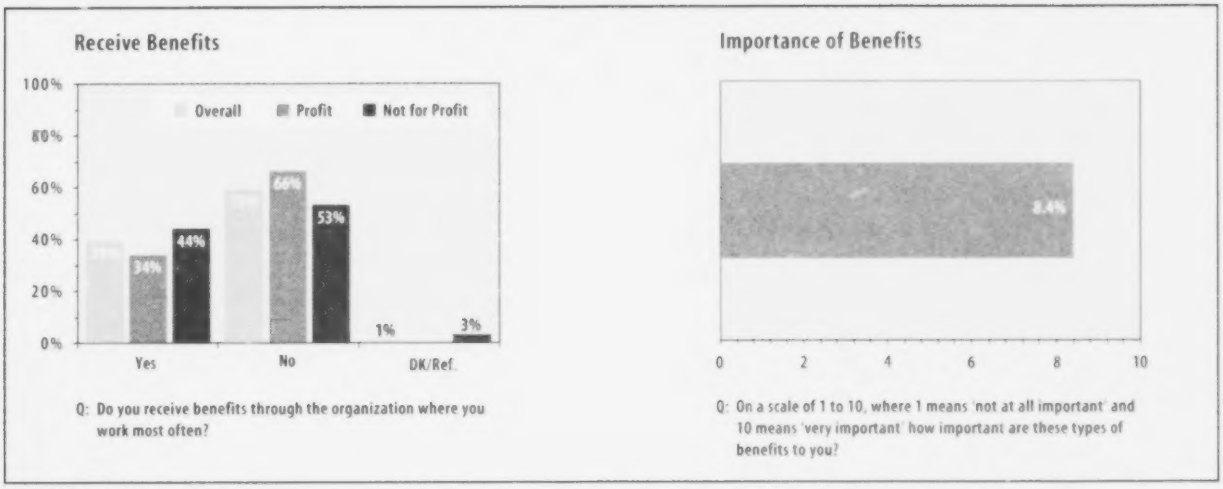

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In 1998/1999 the MOHLTC implemented a 5-year annual, $10 million bridge-funding program to upgrade the skills of workers in community support service agencies. It is estimated that this funding provided 1,325 PSWs with basic training and 1,464 PSWs with palliative care training.[52]

PSW training provides basic training in personal care and homemaking, combining the former roles of Home Support Worker, Health Care Aide and Attendant Care Worker. This training is provided in community colleges, private vocational schools, and some boards of education that train adults. PSWs are unregulated workers and graduate with a certificate of completion.

The Ontario Provincial Auditor's 2004 report stated that there has been no formal evaluation of these programs since their inception.[53]

Recommendation 16: Reward excellent employment practices of service providers with additional points in the RFP evaluation process once Preferred Provider status is achieved.

Recommendation 17: The OACCAC and service provider associations to consider setting basic employment standards for the industry, including dental, drug plans, pension and mileage.

Recommendation 18: As new contracts are awarded, eliminate elect-to-work as described in the Employment Standards Act in home care so that all workers receive full coverage under the Employment Standards Act related to paid statutory holidays, notice of termination and severance pay.

Recommendation 19: The OACCAC to establish a steering committee with provider associations and the Ontario Hospital Association to begin necessary planning for the elimination of elect-to-work.

Recommendation 20: Remove barriers to entering the home care workforce. CCACs not to require 100% PSW status within the procurement process. Employers to commit to training and supervision of personal support workers until they achieve PSW status, generally within two years from the date of hire.

Recommendation 21: MOHLTC and Ministry of Colleges and Universities to evaluate PSW training programs. The evaluation to include both length and content of the curriculum, and be completed before any changes are permitted or funded.

How to Move From Elect-to-Work to Part-Time

- Implementation begins with new contracts.
- Establish a stakeholder working group to ensure a smooth transition.
- In the RFP evaluation, service providers required to show that all employees are subject to the Employment Standards Act, and that none are working under the Elect-to-Work Model.
- Thereafter, as part of the annual certification process, service providers required to show that employees are not working under the Elect-to-Work Model.

How the Move From Elect-to-Work Will Benefit Employees

- All workers will receive pay for statutory holidays and severance packages.
- As a general rule, notice is one week/year of service to a maximum of 8 weeks. For employees that have greater than 5 years of service, they are entitled to receive severance pay in the amount of one week/year of service to a maximum of 26 weeks.

Better Procurement Practices:

Enhancing Consistency and Transparency

Improving the consistency of procurement practices in the home care sector is paramount to developing a system that is fair and as transparent as possible. CCACs were established as separate arms-length corporations. Over time, each developed its own procurement practices based on the foundation documents set out by the MOHLTC. The MOHLTC, OACCAC and CCACs have taken positive steps toward enhancing consistency across the sector. The introduction of the common RFP template was a major step forward for co-ordination across the province. There is, however, general agreement that additional opportunities exist to enhance procurement consistency and transparency.

Feedback from Submissions and Consultations

(i) RFP evaluation practices vary across the province.

Service providers told the Procurement Review that there are inconsistencies in RFP evaluation processes. Even with a common RFP template, evaluation methods vary across CCACs. These variations occur in the evaluation of the RFP document, site visit and interview.

Furthermore, the information provided by CCACs to bidders before and after the RFP is inconsistent. Service providers informed the Review that they would like to see more standard information provided to increase predictability on how the process will work. They want as much information as possible before and after the process in order to structure their bids appropriately and learn from unsuccessful bids. Service providers also said that they would like to see consistent approaches to briefing and debriefings, including common briefing and debriefing tools. They would like to have access to more information before bidding so that they can better prepare their documents. After the competition, they would also like more information to evaluate their proposals relative to the winning bid. They wanted evaluation to be based on common tools and objective criteria.

According to stakeholders, there is a lack of consistency with regard to how service providers are expected to address local concerns in the RFP. They are 'guessing' the relevant local issues instead of focusing on how they would address the local issue. Concerns were also raised as to how one determines which local issues are 'unique,' and should be mentioned in the RFP document. Service providers said that they would like to see the CCACs identify the main local issues of concern, with bidders identifying additional local issues as appropriate.

Some submissions expressed concern that evaluation teams vary in composition, size and skill level. Lack of consistency in evaluation teams can mean inconsistency in interview approaches and scoring.

Under the current system, site visits are optional and the RFP document is given heavy weighting in the decision-making process. Some service providers said that the site visit would give them an opportunity to validate the material in their RFP document. Many service providers would like to see site visits given more weight.

Stakeholders suggested that all aspects of the home care procurement process merit evaluation. For example, service providers said that they would like to see evaluation of the CCACs, with a view to improving consistency, continuous improvement and benchmarking.

Site Visit Evaluation

- Site visit to be used to verify statistics, data, policies and procedures. For example, estimated severance cost could be validated using employee records.

Features of a Common Evaluation Tool

- Evaluation tools should emphasize client outcomes and be kept up-to-date.
- All evaluation tools must be kept confidential. Confidentiality may be achieved through the use of modules. Evaluation teams may be permitted to select questions from a number of modules. This variability helps keep the tools confidential. Alternatively, evaluation teams may ask a full range of questions from the modules, and only score selected questions.

Features of Common Briefing and Debriefing Tools

- A common approach to briefing bidders on RFP requirements and relevant statistics should be developed.
- All debriefing sessions include information on: the total score, the strengths and weaknesses of bidders, the overall winning bid price, and ranking on value for money.
- Contract holders encouraged to debrief subcontractors.

Common Features of Evaluation teams

- Teams could include employees of the local CCAC, one or more community representatives, a member of an outside CCAC, and/or a representative of the LHIN, once in place.
- Non-CCAC evaluation team members should receive a per diem plus expenses to recruit highly qualified candidates.

Key Findings

(i) There are inconsistencies in evaluation practices.

The 2000 PriceWaterhouseCoopers review of the CCACs found that there were inconsistencies in evaluation processes between CCACs across the province.[54] The Procurement Review determined that this problem still exists. There are no common evaluation tools in use across CCACs. On a positive note, many CCACs have developed their own tools and some have begun working towards the development of shared tools.

The IBM Survey of CCACs found that the type of information shared at debriefings is not consistent across CCACs. This survey also noted that information shared at debriefings may include strengths and weaknesses of the proposals, information about individual scores, or varying information about the scoring process. Some CCACs also provide unsuccessful bidders with information about the evaluation process section by section.[55]

A large portion of the RFP template is concerned with asking service providers to identify local issues that are unique. Service providers find it difficult to independently determine this information. For CCACs, the main concern is that providers can demonstrate that they can address these issues, rather than identify which are unique and of utmost importance.

The IBM Survey of CCACs also found that size and composition of evaluation teams varies across CCACs. Reasons for this variation include: availability of qualified evaluators; complexity of the service/stream being procured; and number of submissions received. The study highlighted the importance of appropriate evaluation committee composition, including involvement of external committee members. On average, CCAC evaluation teams have 5-6 members, the majority being CCAC staff. Almost half of CCACs (47%) supplement their teams with external team members. Compensation for participation in evaluation teams varies. External members generally received an honorarium ranging from $25 to $2,000, with a median amount of $100.[56]

There is no process for stakeholders to evaluate CCACs on a regular basis. Consistent evaluation tools and procedures would be welcomed by all. Scoring needs to be more transparent and place a greater emphasis on ability to demonstrate commitments made in the written RFP document. Site visits are an important method to verify documented commitments.

(ii) Current resources are appropriate to fund procurement procedures.

The Procurement Review was asked to assess whether the resources required by the CCACs and service providers are reasonable in the administration of the current policy, procedures and standard template document. CCACs did not raise major concerns regarding the workload related to administering the procurement process. The IBM survey reported that a total of 40 contract managers were in place in CCACs. (Note: This figure does not include the presence of non-management staff involved in contract management departments.) The Review received estimated procurement cost information from the Simcoe CCAC during its recent nursing and support services procurement process. The Simcoe CCAC reported that the entire process took approximately nine months at an actual cost of $230,000. This represented expenses less than .25% of the total contract value.

Although the Review recognizes that there may be additional time required in the future for contract monitoring, this can be adequately resourced through existing CCAC contract management resources and, if necessary, through reallocation of existing CCAC administrative staff.

Flexibility in Implementation

- Tools developed for the interview and site visit should retain some flexibility so that CCACs can validate information in the written document through due diligence and cross-referencing.

For service providers, the Review found that small providers in particular expressed concern about the amount of resources and time required to prepare RFP documents. This is addressed in Section 8 of this Report.

Recommendation 22: Revise the scoring system for quality evaluation and have the written document, the interview and the site visit be of equal value.

Recommendation 23: Develop consistent evaluation tools based on objective criteria for the RFP written document, interview and site visit. Site visits to be mandatory for eligible bidders (those bidders that have passed the written document and interview stage at a score of 75%). Evaluation tools to include modules that take into account large/small, urban/rural regional differences.

Recommendation 24: Include a disclaimer in the RFP to make it known that as an agent of the government, CCACs are subject to PIPEDA and the Freedom of Information and Protection of Privacy Act which means all information under the care and control of CCACs may be subject to disclosure.

Recommendation 25: Develop common briefing and debriefing tools so that CCACs provide all bidders and subcontractors with common information. As part of the debriefing, the price of the winning bid to be made public.

Recommendation 26: CCACs to clearly specify the local issues that need to be addressed in the procurement process. CCACs to evaluate service providers on local issues only where these issues clearly have an impact on service delivery.

Recommendation 27: The composition of evaluation teams to be consistent across CCACs. All teams to be composed of 5-7 members with at least one member from the Community.

Recommendation 28: The OACCAC to develop common survey tools for stakeholders to evaluate CCACs. The survey of CCACs to be an anonymous annual survey of stakeholders including contracted service providers, clients, community organizations and hospitals.

Features of CCAC Evaluation

- CCACs to be regularly evaluated on both the process and results of procurement procedures.
- A scorecard on CCAC performance should be developed and implemented initially by the OACCAC, and ultimately with the CQR. The scorecard to be in keeping with the intent of the Health Results Team - Information Management.

Getting Value for Money

Once a high threshold for quality has been established for service providers, assuring value for money through reliable procurement practices is of particular importance. Neither price nor quality should be viewed in isolation. In order to ensure the best value for tax dollars, there should be a correlation between the two. There is a need to collect information on quality and price to assess these two aspects of an RFP submission. The information required is addressed with the creation of the Centre for Quality and Research discussed earlier in the report.

Feedback from Submissions and Consultations

(i) Prices have not been contained with the new procurement model.

Economic theory suggests that competition with multiple bidders should result in the lowest price, given perfect market conditions including easy market entry and exit. However, health care, like other service markets, is well known for imperfect market conditions that can lead to higher than expected costs. In addition, these markets entail transaction costs that can be considerable.

Stakeholder feedback suggested that prices have increased with the move to competitive bidding. One explanation for this apparent inconsistency is that prices may have been artificially below market, and have now adjusted to market value in light of competition. Another explanation is that bidders are unsure of the volumes they will be awarded and come in with higher bid prices as a result. The Procurement Review also heard that, under the current formula (75% quality and 25% price), there is no strong incentive for bids to be cost-effective.

Several stakeholders felt that, despite the Government's commitment to evaluation of the RFP on the basis of 75% quality, many RFP contracts were awarded to bidders offering the lowest price.

Service providers also said that during renewal negotiations, current market conditions were not always taken into account, leading to contract renewal prices that were artificially low.

Finally, there is variation in the application of scoring formulas, resulting in inconsistent evaluation across the province.

(ii) Some bids are automatically eliminated.

CCACs told the Procurement Review that they have the authority to eliminate the lowest or highest bids. They expressed concern about the lack of guidelines to apply this policy effectively. Service providers raised a concern that bids could be eliminated from the procurement process without assessment simply because they are seen to be out of range on price.

(iii) Current caregiver remuneration creates negative incentives.

The current system funds providers on a per visit basis. The majority of home care workers are remunerated on a per visit basis. Some are paid by the hour while some receive full-time and part-time salary.

Stakeholders said that the current payment approach leads to the potential for decreased quality of care because workers are paid on the basis of the number of clients seen, rather than on meeting needs. Clients said

that they would like more say in the types of services they receive. Some also said that more service at the start of recovery may be preferable, even if service declines as the person recovers. Some days, a phone call may suffice. Nurses and therapists also said they would like more time with clients and more flexibility in allocating their time.

Submissions received by the Procurement Review support these sentiments. The Ontario Association of Social Workers notes, "weighting of services based on per visit costs results in cost rather than client need driving referral for services."[57]

Key Findings

(i) Prices are higher and closely clustered.

Research conducted by IBM highlighted that in 29 instances, the price proposed by the existing service provider was significantly higher (more than 15%) than the price being charged previously. In five instances since the introduction of the new RFP template, the fixed visit price proposed by the existing service provider was slightly lower than price charged previously.[58] There are two possible explanations:

(1) Existing service providers may have lower prices than new providers because they do not have to incur start-up costs.

(2) Existing service providers have a better sense of the true cost of service provision and can identify more realistic prices.

A review of recent evaluation results also showed a close clustering of both quality and price scores making it difficult to differentiate between service providers.

The Procurement Review found that CCAC guidelines prohibit an automatic awarding of the contract to the lowest price. MOHLTC policy clearly states that RFP proposals must be evaluated 75% based on quality and 25% based on price. Price envelopes are only opened after the quality threshold of 75% has been met. All other envelopes are returned unopened. Consequently, the Procurement Review could not definitively determine how often the lowest bid was the one awarded the contract (i.e. unopened bids could have lower prices).

In the absence of a competitive process during contract renewal, there currently is no means to objectively verify provider claims about changes in market conditions.

The Procurement Review discovered that there are two price evaluation formulae in use. Because there are two formulae and the price evaluation cannot be disclosed, this has led to assertions of unfairness and lack of transparency. We found that the pricing formula that maximizes differences between prices increases fairness in evaluation.

An objective calculation for evaluating value for money should be explored because the best price is not always the best bargain. There is a strong relationship between quality and price. Introducing a value for money score could enhance due diligence by highlighting any unexplained anomalies in the allocation of resources. It could also encourage service providers to be cost effective and offer a clearer assessment of differences between organizations.

(ii) Eliminating bids may stifle innovation.

A review of procurement pricing models indicated that eliminating a low or high bid may send a message that keeps providers from trying to reduce costs, or coming forward with a very high quality, but expensive bid. There may be valid reasons why a bid price is not in line with other provider prices.

(iii) The current payment system is inflexible and does not focus on client outcomes

The Procurement Review found that the pay-per-visit system does not allow caregivers to receive compensation for telephone or conference calls among the caregiver team. It does not allow for flexibility in length of time of visits as the client improves.

Under the pay-per-visit model, there is an incentive for the workers to undertake as many visits per day as possible. The Review heard reports of nurses carrying out

as many as 25 visits per day. Most caregivers agree that this indicates a problem with quality of care. These findings were echoed by the Ontario Provincial Auditor's Report that calls for a funding model based on need.

In its examination of possible payment models, the Procurement Review concluded that a care envelope funding model provides more flexibility to tailor care to meet clients' needs. It can be based on the achievement of client outcomes, rather than the number of visits, thus providing better incentives for appropriate care.

Moving to an alternate-funding envelope can provide needed incentives to encourage client participation and flexibility in meeting client needs. When the envelope is developed, the expected client outcomes should be identified.

Recommendation 29: Until such time as the CQR introduces a value for money or new pricing formula, all CCACs to use a common formula for price evaluation that best reflects pricing differentials.

Recommendation 30: The CQR to evaluate new pricing formulae to address current concerns, including a value for money formula for those who pass a quality threshold of at least 75%. The score to be calculated as follows:

$$\frac{\text{Price} - \text{estimated severance}}{\text{Quality}} \times 100 = \text{Value for Money Index}$$

Recommendation 31: Conduct information interviews for high bids (15% above the highest bid) and sustainability interviews for low bids (15% below the median). The sustainability interview to determine whether the service provider should be disqualified. This applies only to those service providers that have been identified as being eligible for a contract.

Recommendation 32: Implement the Ontario Provincial Auditor's recommendation to move toward a funding formula based on need by shifting to client-focused envelope funding. Begin demonstration project with eight CCACs, with the goal of expanding the alternative funding model to all CCACs by 2010.

Alternate Funding Demonstration Project

Goal:

The purpose of the Demonstration Project is to develop an alternative funding model for a variety of home care clients that will provide more flexible and responsive care and service to clients. Over the course of this two year project, a new client envelope funding model will be developed for all appropriate client groups, and the impact of this new model on client outcomes and home care worker satisfaction will be determined. It is intended that results from the project will be disseminated widely and adopted quickly throughout the Province.

Objectives:

1. To develop a reliable alternative funding model for home care that will replace the current fee-per-visit model for targeted client service populations.
2. To identify local and regional variation in types of services provided, and the impact, if any, on client outcomes.
3. To establish parameters for the intensity of case management services offered to clients.
4. To clarify the role of the case manager and provider agency care coordinator(s) in an alternative funding model.
5. To develop predictors of resources allocated to similar groups of clients.
6. To establish a variety of performance metrics and improve the comparability of this data.
7. To consider the implications of an alternate funding model on procurement, contract monitoring and the funding formula for CCACs.

Format:

At the time of this report, eight CCACs expressed an interest in participating in the demonstration projects by working with the lead researcher to develop a full project proposal (Durham, Eastern Counties, London, Near North, Ottawa, Peel, Peterborough, and Simcoe). It is recognized that there are organizational changes occurring in the broader health system, and the exact configuration of participating sites may be different based on these changes.

Project Management:

A lead researcher will oversee the development of the full project proposal and conduct the evaluation of the project. A project manager will provide oversight and coordination to the project. Each participating CCAC will identify a project coordinator.

Accountability:

Accountability structures and protocols will be established as part of the full project proposal. They may include a Steering Committee and subcommittees such as data reliability/validity and evaluation. Sponsorship of the project will be through the Change Foundation, with participation on the Steering Committee sought from the MOHLTC, CCAC Branch , and the OACCAC.

Timeframe:

The project to commence Spring 2005 and be completed by Spring 2007.

Principles:

- A mix of sites participating in the demonstration project to reflect differences in the demographics and size of CCACs.
- Quickly adopt alternative funding envelopes developed for specific client groups.
- In developing the alternative funding model for home care, consider incorporating research that has been done related to funding models and the RAI assessment as well as alternate funding models for hospitals and physicians
- Use the alternative funding project to strengthen linkages with Family Practice Teams.
- Develop a cost-neutral alternative funding model.

Anticipated Project Outcome:

- 80% of CCACs will use an alternative funding model for relevant client groups by Spring 2008
- 100% of CCACs will use an alternative funding model for relevant client groups by 2010.

Strengthening Not-For-Profit and Low Volume Providers

Home care in Ontario has always been publicly funded through tax dollars and primarily delivered by private (not-for-profit and for-profit) agencies. Local, community-based, not-for-profit agencies, in particular, have always been a valued contributor to the delivery of trusted home care services in the province. In addition to providing home care, they encourage volunteerism and offer a strong mechanism for community support.

The CCAC Procurement Review recognizes the valuable contribution of more than 800 agencies already receiving funding from federal, provincial or municipal levels of government to provide Community Support Services. Community Support Services are those that can be accessed directly by seniors, persons with physical disabilities, adults with HIV/AIDS and adults with acquired brain injuries (ABI) to help them function as independently as possible in the community. These services include: portable meal programs; community transportation; respite care and friendly visiting; supportive housing; adult day programs, home maintenance and repair, security checks, social and recreational services, and a variety of ABI services.

In keeping with the legislation governing the procurement process, service providers are being selected solely on the basis of their ability to deliver home care services. Good procurement practices evaluate the provider's ability to meet the stated requirements in the RFP to ensure that like services are being compared fairly (i.e., "apples and apples"). In order for the competition to be fair, those evaluating the RFP can only compare like services, not related or complementary services. While these other services are important and merit continued support from all levels of government, it is inappropriate to consider them as part of the RFP evaluation process.

Feedback from Submissions and Consultations

(i) When not-for-profits lose, the community suffers and other valuable local services are lost.

The Procurement Review heard that when not-for-profits lose CCAC contracts, clients can also lose extra services that have historically been provided to meet local community needs. Another adverse effect is that volunteers may also be lost when not-for-profits are no longer able to sustain themselves. Some not-for-profits argued that they should get extra points in the procurement process for offering extra services, or these services should be subsidized through other government funding. It was also suggested that not-for-profits should get first right of refusal on all CCAC contracts.

Some argued that the not-for-profit sector as a whole offers better quality because not-for-profit organizations are not motivated to accumulate profits. Submissions pointed out that due to their connection to the local community and experience, not-for-profits are better able to co-ordinate a broader range of services to meet clients' specific needs.

Other smaller not-for-profit providers said that in order to successfully compete in home care they are specializing in providing services to niche markets such as specific linguistic or cultural groups. Still others said that they are not equipped to compete.

Some service providers said that they used to receive credit for including subcontractors in their delivery teams. This does not occur under the new template.

FIGURE 9: % Nursing Volumes by Fiscal Year

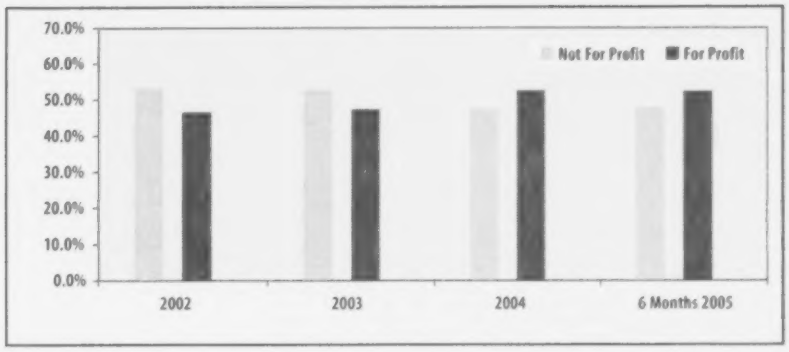


FIGURE 10: % Personal Support/Homemaking by Fiscal Year

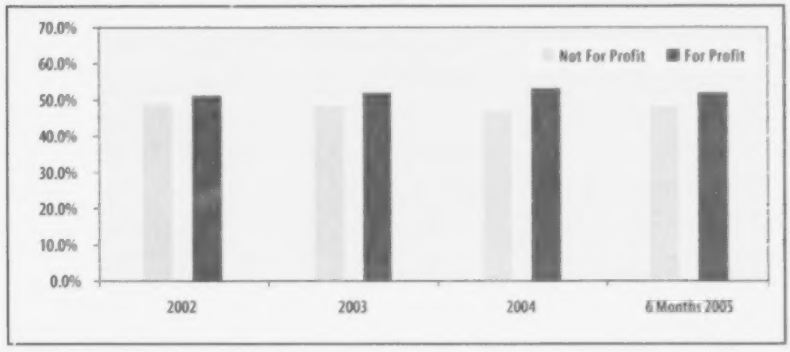
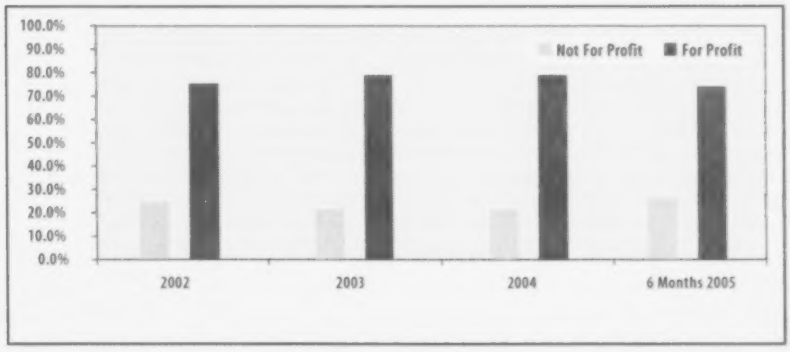


FIGURE 11: % All Therapies by Fiscal Year



On the whole, stakeholders expressed concerns that the not-for-profit sector is losing market share to the larger for-profit agencies.

(ii) No incentive for development of creative partnerships.

The RFP requirements make it difficult to form joint ventures, consortia and partnerships. This has discouraged larger organizations from partnering with smaller ones. This has prevented smaller agencies such as not-for-profits from benefiting from pooled resources.

VHA Home HealthCare noted in its comments to the Review that "most agencies, VHA included, are extremely reluctant to be forced into corporate arrangements with service partners. It is costly and unwieldy to form a separate corporation with its own articles of incorporation, by-laws, meetings, boards, finances, etc." VHA would not enter into these potentially beneficial arrangements if forced to spin-off numerous corporate structures. Providers also said that joint ventures are particularly helpful in instances of multi-service RFPs where providers do not undertake all of the relevant services themselves.[59]

(iii) Not-for-profits and small providers disadvantaged due to complexity of RFP.

Finally, several stakeholders were concerned that some not-for-profit agencies are at a disadvantage because completing the RFP is complicated and expensive. Small providers were particularly concerned that the template document does not ask questions appropriate to small, single-stream providers. Many expressed a desire to

see more emphasis on interviews and site visits which would give them an opportunity to demonstrate what they can do, rather than relying on professional skills in preparing proposals.

Key Findings

(i) There is a need to build capacity.

The MOHLTC provided the Procurement Review with the results of an informal survey it conducted in the late 90's on the proportion of not-for-profit and for-profit contracts. The survey that found that 51% of the providers in the sector were not-for-profit and 49% were for-profit agencies. The Review used this data as a baseline to compare changes in the sector since the introduction of managed competition. The MOHLTC policy protected volume distribution based on 1995/1996 levels to assist in the transition to the new procurement model. Volume protection ceased in 1999/2000.

Figures 9-11 illustrate data provided by the OACCAC outlining the fluctuations in service volumes for both not-for-profit and for profit nursing, personal support services and therapies since 2002. Historically, therapy services have been provided by for-profit providers, often in individual or group practices.

A separate study by Doran, Pickard, Harris, Coyte, MacRae, Laschinger and Darlington (2002), funded by the Canadian Health Services Research Foundation reported a marked increase in the total volume of nursing services from 1995 to 2000. The volume of nursing services provided by not-for-profit agencies declined marginally following the introduction of competitive bidding, while the market share experienced by for-profit agencies increased substantially during the same period.

Since the introduction of the new template in 2003, market share has been redistributed as shown in Table 5.[90]

While these findings do not demonstrate significant fluctuations in the overall volume of cases serviced by the not-for-profit or for profit agencies, the Review did find that there have been significant changes to the volume served by regional not-for-profit providers offering community support services.

Current statistics received from the OCSA show that only 7 out of 18 regional not-for-profit agencies that receive government funding for Community Support Services have retained contracts with CCACs. One explanation is that the Community Support Services program does not require that participating agencies have a quality management structure. Consequently, with the introduction of the RFP template that placed heavy emphasis on quality systems, many of these agencies found it difficult to compete.

The Procurement Review clearly heard that the extra community support services provided by the not-for-profit sector are highly valued by both the clients and the communities. The potential for community support services to be lost as a result of lost contracts with CCACs is of concern. While CCACs are mandated to procure only for legislated services, the potential for cost savings and more comprehensive client care from the additional community support services merits continued support for these services from government and other sources.

TABLE 5: Market share since introduction of new RFP Template

	Not-for-profit before new template	Not-for-profit after new template	For-profit before new template	For-profit after new template
Nursing*	49%	55%	51%	45%
Personal Support and Homemaking**	47%	41%	53%	59%
Therapies***	15%	33%	85%	67%

* Results reflect 24 procurements by 13 CCACs

Source: IBM Survey of CCACs

** Results reflect 13 procurements by 11 CCACs

***Results reflect 14 procurements by 5 CCACs. Most providers are individuals who have been classified as for-profit providers.

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***Results reflect 14 procurements by 5 CCACs. Most providers are individuals who have been classified as for-profit providers

(ii) The relationship between corporate structure on quality and price is extremely complex.

The Procurement Review found no evidence to support the superiority of either the for-profit or not-for-profit agencies in delivering service to clients. The relationship between ownership structure and access/price/quality depends upon a variety of factors. As University of Toronto professor, Raisa Deber noted in her submission to the Romanow Report, for-profit firms must be responsible to shareholders and have a legal obligation to maximize profit. This may encourage them to choose certain types of cases or services over others, make different decisions about worker remuneration and skill mix and, in extreme cases, to skimp on quality. On the other hand, both for-profit and not-for-profit organizations owned by licensed professionals (e.g., nurses, physiotherapists, etc) may be less susceptible to these pressures unless market forces compel a race to achieve the lowest price. When there are appropriate and effective monitoring mechanisms in place, excellent results can be achieved with any ownership structure. However, transaction costs can be considerable and oversight mechanisms may wish to balance the issue of trust with the costs of surveillance and monitoring.[61]

On the other hand, Doran et al. (2002) found that clients cared for by for-profit agencies reported quality in nursing at least as good, or slightly higher than not-for-profit agencies. They also found that differences in nurses' work enjoyment, satisfaction with time for care, and job security varied by agency, but were not related to corporate structure.[62] The Pollara survey of home care workers compared the perception of the number of clients served per day by for-profit and not-for-profit agencies. Based on survey data, for-profit workers served fewer clients per day than not-for-profit workers and spent slightly longer with individual clients.[63] There is no conclusive evidence to show that corporate structure determines cost effectiveness. Doran et al (2002) also reported that the average visit rates paid by CCACs to for-profit and to not-for-profit agencies were converging from 1995 to 2001.

Research on wage rates is difficult to assess due to differences in geography and other factors. Research on wage rates for all services is limited. More research needs to be done in this area.

(iii) Address special needs of smaller agencies in completing the RFP.

Some organizations, especially small agencies, find it difficult to be successful in responding to the RFP because they may not have experience in collecting relevant data and implementing formal quality management systems. As a result, these organizations find it difficult to demonstrate their ability to provide quality service through the written document.

The Procurement Review also found that, although permitted by the RFP process, CCACs were not making effective use of small streaming to address the issues of smaller service providers.

(iv) Barriers to innovative partnerships exist.

The pre-qualification documents for tender, entitled Joint Venture Company, state that CCACs "may require the successful (joint venture) Respondent to incorporate a separate legal entity, comprised of the joint venture participants, prior to entering into the agreement." As a result of this requirement, the Procurement Review found limited use of joint ventures.

Niche service providers need more ability to form partnerships, and to use small streams. Smaller agencies should be given a greater opportunity to demonstrate their quality of service through means other than the written RFP document.

Recommendation 33: The Government to build capacity in quality management in agencies receiving direct government funding for CSS through the creation of training and educational opportunities.

Recommendation 34: In the event of a tied score (quality and price scores are equal), and the incumbent is not part of the tie, service providers receiving direct government funding for Community Support Services to receive preference.

Recommendation 35: Amend the RFP and RFQ so that there is no requirement for service providers to create a new legal entity if they wish to enter into joint ventures, consortia and partnerships. CCAC approval to be sufficient for sub-contracting.

Recommendation 36: Allocate up to 15% of total service volumes to small-streams to facilitate contracts for low-volume and niche providers, and to encourage new entrants to the market.[64]

Recommendation 37: Develop a simplified RFP to meet the needs of small-volume providers.

Qualifications to the Preference

- Where quality and price evaluation scores are equal, give first preference to the incumbent service provider to encourage greater stability.
- Disclose where preference has been invoked.

Training and Educational Opportunities

- Where agencies have no CCAC contracts or two or fewer CCAC contracts and are receiving funding from government for Community Support Services, the OCSA to provide training opportunities on quality management and procurement skills.
- MOHLTC to provide funding to the OCSA to take on this role.

Stimulating Innovation

The goal of the CCAC Procurement Review is to create an environment of continuous improvement, enhance client service, and improve quality of care through innovation.

Feedback from Submissions and Consultations

(i) There is no incentive to foster Innovation.

Service providers said that although the RFP template asks for innovation, there is limited incentive for innovation in the system. There also is no incentive to share innovations between providers. In fact, the procurement process fosters a climate whereby service providers keep innovations to themselves in order to demonstrate that they are innovative in the next RFP.

Clients informed the Procurement Review that they would like to see more innovative options for care and treatment, including options for care in a clinic setting where transportation was provided. Some clients noted that this would help improve socialization for many that find it hard to get out of their homes. Others were interested in greater access to telemedicine.

Key Findings

(i) Increase flexibility for CCACs.

CCACs are currently limited to $150,000 in spending outside of the procurement process. CCACs have used this exemption to fund innovative projects and initiatives.

The Review also learned that while hospitals are permitted to keep budgetary surpluses, CCACs are required to return any unspent funds at the end of the year. This can stifle support for innovation and lead to inefficient or inappropriate spending practices.

Increasing flexibility and providing incentives for innovation will lead to new, more efficient and more effective service-delivery models.

Recommendation 38: Give CCACs more flexibility to encourage innovation by increasing the current exemption from RFP from $150,000 to $250,000 per contract per year. CCAC boards to approve all RFP exemptions and also notify the CQR of innovations funded in this manner.

Recommendation 39: Allow CCACs to re-profile up to 5% of their budget annually. This 5% to be directed to a reserve fund to balance future budgets or be used for one-time expenditures.

Recommendation 40: Give service providers credit in the RFP for innovations that improved efficiency and effectiveness. CQR to widely disseminate information about innovations developed in financial partnership with the CQR or a CCAC.

Medical Supplies and Equipment

The CCAC Procurement Review's objective is to see that procurement of supplies and equipment results in the most appropriate quality product and service being available at the right time, at the right place for the right price.

Currently, CCACs are responsible for the procurement of equipment and supplies used to support client care. Supply costs in 2002/2003 accounted for $76.5 million (6.5%) and in 2003/2004 increased to $88.8 Million (7.3%) of the total budget for CCACs. These expenditures may be understated as some CCACs capture medical supplies as part of purchased services. The total annual expenditure on equipment costs was $21.8 million (1.9%) in 2002/2003 and increased to $22.8 million (1.9%) in 2003/2004[65].

There are four major categories of client care supplies and equipment:

- Medical/surgical supplies (including items such as bandages and syringes);
- Medical equipment supplies (including items such as specialized beds, baths, IV equipment, and home oxygen);
- Infusion therapy supplies; and
- Community laboratories which provide blood and specimen collection services to some CCACs for a nominal fee.

In addition, people receiving professional services under home care, who are Ontario residents and have a valid Ontario health card, are eligible for coverage through the Ontario Drug Benefit program. The Drug Programs Branch of the Ministry of Health and Long Term Care indicated that the total cost of drugs provided through this program for home care was over $108 million in 2004/05.

Feedback from Submissions and Consultations

(i) Medical/surgical supplies need standards for quality.

Suppliers said that supplies vary in quality. For example, not all bandages are equal, and treatment with better quality supplies can speed healing. In addition, standards and requirements for purchasing supplies vary across CCACs. Suppliers encouraged the Procurement Review to keep a focus on consistent quality in the procurement process of supplies.

(ii) Suppliers need to properly amortize the cost of equipment.

Suppliers also said that short contracts increase costs, especially for equipment suppliers who amortize the cost of equipment over the life of the contract. Contracts currently range from 3-5 years in length, which is insufficient.

We heard that CCACs lack expertise when it comes to developing specifications for the procurement of equipment. Equipment must be properly maintained and cleaned, delivered on time, with proper instructions given for use. Standards for infection control practices are particularly important with more complex equipment rentals. Standards are not uniformly articulated for this

type of equipment. For example, there are also inconsistent levels in the quality of compounded IV solutions in the community.

(iii) Infusion services are complex and need expert evaluation.

Due to the pharmaceutical component of infusion, therapy providers reported that pharmacists must be involved in evaluation of these services. Currently, they are not. Standards are not in place for the preparation of infusion therapy. Suppliers said that standards in the community should be at least as high, if not higher, than those used in hospitals.

(iv) Suppliers want more consistent procurement practices.

Several suppliers said that CCACs often don't provide sufficient information on supply and equipment utilization rates, expected volumes and the geographical distribution of clients. This lack of information prevents suppliers from making informed business decisions and setting realistic prices. Lack of information has resulted in some companies putting in unsustainably low bids, which put them out of business. Likewise, the Review heard that prices may be inflated to ensure suppliers aren't left short.

Specific concerns voiced by suppliers include:

- Pricing should allow for separate delivery charges and daily rates.
- There are inconsistent billing procedures and definitions across CCACs.
- Specifications for supplies and equipment should be developed.
- There should be consistent specifications for financial statements.

CCACs stated that they want certainty in pricing by having an "all in" bid price. They generally do not allow for separate pricing for same-day requests, short rentals of equipment and delivery charges. Suppliers said that this transfers all the risk and additional cost to the supplier.

Suppliers also reported that some CCACs change their policies mid-contract when they need to balance their budgets (e.g., equipment rentals averaged 58 days and due to cost containment, were reduced to 30 days). Suppliers who had built their price bids on a 58-day rental were negatively affected in terms of their bottom line. Suppliers also noted that other unanticipated reductions in service volumes to clients impacted their bottom line.

Importantly, the Procurement Review learned that contract monitoring by the CCACs of supplies and equipment rarely occurs.

(v) There is too much waste of supplies.

Suppliers and service providers noted that there is too much wastage of unused supplies. In some cases, it is not economical for suppliers or service providers to collect unused supplies from the CCAC. There also are infection control issues related to the redistribution of sterile supplies. As well, there are no incentives for caregivers to order the proper amount of supplies.

Features of procurement process for supplies and equipment

Standards for Tenders

- Develop appropriate quality standards for all tenders.
- Most contracts for supplies procured through tender.
- Contracts for equipment will generally be procured by RFP.

Longer Contracts

- Structure contracts for supplies and equipment for up to a 6-year term to allow for amortization of capital costs over a longer period.

Key Findings

(i) Consistent standards are needed for supplies and equipment.

The Procurement Review found that there are no consistent standards/specifications for supplies and equipment that have been adopted by all CCACs. In March 2005, a committee of CCACs completed the first phase of work to create a common medical equipment list, and related policies and practices. The objectives of this group are to develop medical equipment policies, identify best practices, create a common list of medical equipment, and establish common performance indicators. Phase two will focus on developing common RFP elements for equipment. Unfortunately, there was no evidence of similar work underway for supplies.

Where consistent standards exist, a tender process may be adequate for supplies, and should result in the best price - provided that conflict of interest guidelines are included.

(ii) There is a greater service component in providing equipment.

Equipment generally has a higher service component than supplies. Where there is a significant service component, the best value can be achieved by using an RFP.

How to enhance consistency of procurement process

- OACCAC to develop standardized Product Supply and Equipment Specifications.
- OACCAC to lead the development of consistent electronic ordering and billing procedures, and develop consistent policies on the length of equipment rentals.
- Hold semi-annual meeting with suppliers to discuss performance and monitor contract.

The Procurement Review was encouraged to hear that a group of CCACs has begun to work on the development of common specifications for medical equipment, and are working towards a common procurement policy.

(iii) Standards for Infusion Therapy need to be developed.

Standards for infusion therapy are not available in the community, but are available for hospitals. Development of these standards is complex, and should involve input from pharmacists. Evaluation of infusion therapy providers should be based on quality pharmaceutical standards.

(iv) Community laboratories are working well.

Other than a desire to see greater equity of access to phlebotomy and specimen collection services across the province, there were no major concerns raised regarding laboratory services.

(v) There is limited contract monitoring.

The Procurement Review verified that there is extremely limited contract monitoring for supplies and equipment.

(vi) Supply waste can be reduced.

The collection of unused supplies varies across CCACs. Some CCACs are more active in collecting unused supplies than others. Some CCACs source, deliver and warehouse their supplies, and find this method cost-effective.

(vii) Group Purchasing has started.

In the last year, the OACCAC has led several group-purchasing initiatives. There currently are 16 different initiatives implemented or underway. These initiatives are a good start in dealing with group purchasing of items such as telecommunications and consulting services.

Recommendation 41: Develop a common procurement contract template for medical/surgical supplies and equipment. Use template in cases where there is a significant service component. Use a tender process where there is no significant service component.

Recommendation 42: Evaluation of an RFP for selected supplies and equipment to be based on a 25% score for quality and 75% for price.

Recommendation 43: OACCAC be mandated to establish a stakeholder committee including representatives from the College of Pharmacy, the College of Nurses, and infection control experts to review procurement of infusion therapies and to develop standards. Evaluation of infusion therapy providers to be based on quality pharmaceutical standards.

Recommendation 44: Enhance consistency of procurement through standardization, improved contract monitoring, consistent polices, and the development of consistent electronic ordering and billing procedures.

Recommendation 45: Expand group purchasing initiatives to include major cost items common to all CCACs and LHINs, where appropriate.

Ways to better manage supply costs

- CCACs to capture supply and equipment costs using MIS guidelines and, at a minimum, identify the costs according to the four distinct categories.
- OACCAC to evaluate different approaches for sourcing, delivering and warehousing supplies to determine if there are cost-effective methods (i.e. a best practice), which could be used by all CCACs and/or LHINs.
- OACCAC to explore joint purchasing opportunities.
- Each CCAC to identify a community agency willing to pick up unopened but useable supplies.

Creating a Home Care System Using Information Technology

Investment in information technology (IT) is a critical enabler for achieving a strong home care system. A number of initiatives are underway both within CCACs and within the government to address shortcomings with current information technology and information management solutions.

Over the past several years, CCACs have successfully implemented a number of technology initiatives, including the development of secure e-mail, common financial and statistical systems, and case management software. They have created a team called bat.com, which is a group of CCAC leaders charged with the mandate to oversee CCAC IT initiatives. They are currently in the process of negotiating a transfer of IT support services from the MOHLTC to the OACCAC by setting up their own computing services.

In the broader context, a new mandate has been approved for Smart Systems for Health (SSHA) within eHealth to deliver technology solutions beyond just infrastructure within the health sector. To facilitate this expanded mandate, it has established a new division called the eHealth Solutions Division. In addition, a new governance and accountability framework has been developed for all eHealth initiatives to maximize the impact and ensure alignment with all health IT initiatives.

Using SSHA technologies, CCAC case managers were able to electronically follow the almost half million clients whose care they coordinate annually. All 42 main offices and many satellite offices across Ontario are connected to the SSHA network. SSHA securely hosts their financial and statistical systems, as well as 20 CCAC web sites.

- The Health Results Team-Information Management (HRT-IM) has identified an ambitious plan to improve the sector's capacity to obtain high quality information by focusing on four streams of work: i) developing an information management strategy; ii) producing better data; iii) measuring performance for change; and iv) supporting better decision making. The team will focus on improving data quality and identifying a few consistent key performance indicators for the health sector, including community and home care.

Feedback from Submissions and Consultations

Disparate information technology systems minimize capacity to collectively measure quality and performance across the sector.

Neither clinical nor administrative data collected is consistent. The collection of reliable performance indicators is almost impossible, making it difficult for policy makers to know whether or not quality is improving in the home care sector. Efforts have been made to develop common indicators through the MOHLTC's Business Planning process.

Currently, most of the IT initiatives in home care are independently governed or have their own steering committees. These projects are relatively separate and distinct, with little or no accountability to the MOHLTC.

We heard that there is continuing work being carried out to establish a unique identifier for each client in the health system. This work will be vital for the development of a comprehensive electronic health record that follows the client throughout the system.

Key Findings

Information technology can accelerate development of a quality home care system.

Research in the home care sector is almost non-existent, and would be greatly enhanced through the introduction of standardized data sets, nomenclature and, most importantly, an electronic client record for home care. The lack of common definitions means indicators are not comparable across CCACs. There also are too many indicators to be meaningful.

There currently is no Information Management and Information Technology strategic plan for the home care sector. The development of a plan would ensure there is a blueprint to guide investment decisions and priorities for the coming years. Such a plan would ensure procurements address custodianship, data standards and information needs while staying aligned with provincial directions. The plan could also outline the systems and technology needed to realize an electronic client record.

It is imperative for service providers, particularly for nursing and therapy services, to access each client's clinical history. This type of an electronic client record is currently in use through the electronic Child Health Network (eCHN). eCHN is enabling more than 50 hospital sites to integrate and share their client data for the use of physicians, nurses, therapists and other authorized health care providers. Caregivers can access an integrated version of the client's chart (including demographic data, clinical notes, operative notes, discharge summaries, laboratory test results, radiology reports and images). This integrated electronic client record consists of information received from any acute care, rehabilitation or chronic care facility from which the client may have previously received care.

The real beneficiaries of such a record are the clients, as a shared, integrated record raises the quality of care and lowers the risk of errors. In addition to the health care providers associated with more than 50 hospitals, eCHN is currently available to nine CCACs and one home care provider (St. Elizabeth Health Care).

Currently, eCHN's database contains those clients who are 19 years old or younger, but could be analyzed to determine the potential for expansion to include clients of all ages.

Consistent data standards will ensure sharing of data and metrics performance. Preliminary work is underway to identify data standards for information and referral but additional investment is necessary to complete the work.

In 1998, the Waterloo Region CCAC, along with local health care providers and stakeholders, established the Community Health Information Network (CHIN) as a secure, internet-based information exchange mechanism to address inter-agency communication barriers. CHIN connectivity and applications enable local providers who deliver community nursing, personal support and therapies to better manage information.

Implementing the Electronic Client Record

- OACCAC to work with SSHA to develop an Information Technology/Information Management Strategic Plan for CCACs that includes the systems and technologies.
- The plan to ensure consistency with the client registration and identification management (CRIM) is a critical element in developing an integrated electronic health record that identifies clients across all sectors. For example the OHIP number could be used as a common health identifier.
- CCACs to develop their own information management plan based on principles used by the HRT-IM group.
- CCACs to have responsibility for the client record, and develop related policies in consultation with the MOHLTC and the Privacy Commissioner.

Recommendation 46: Declare home care a top priority for IT investment by MOHLTC through the eHealth Council and it's sub committee, the Continuing Care eHealth Council, including the Smart Systems for Health Agency. Within home care the focus to be on electronic referrals from CCACs to community providers, common assessment of client need and an application that captures and stores the client's history and is a building block of the electronic health record. If priority status is not granted, allow the OACCAC and the CCACs to proceed in alignment with eHealth Strategies.

Recommendation 47: Coordinate home care with other Government IT Initiatives and assign IT Project Management functions for CCACs to Smart Systems for Health and its Deployment Planning and Management Office. If priority status is not granted, allow the OACCAC and the CCACs to proceed in alignment with eHealth strategies.

Recommendation 48: Consider expansion of the Waterloo Region CHIN and/or other information sharing systems to all CCACs, as part of the consolidation of CCACs.

Recommendation 49: OACCAC to define data standards and nomenclature immediately to ensure easy sharing, consolidation and comparison of data and this should be aligned as appropriate with the work of the Ontario Health Information Standards Council.

Transfer of Children's School Program

CCACs play a major role in providing access to services for children both at home and in schools. Services in the home and in school include: nursing, personal support, provision of supplies, nutrition services and social work. They also include therapies such as occupational therapy, physiotherapy, and speech language services.

Children are a vulnerable group in society and considerable stress is placed on families caring for children with special needs. The CCAC Procurement Review's goal is to ensure that delivery of service to children is well co-coordinated and consistent.

Feedback from Submissions and Consultations

(i) The children's program is fragmented, with little overall coordination.

Families struggle with the co-ordination of care for children who need multiple services as services may come from a number of agencies and from a variety of programs. Families do not have a central location where they can access all the services they need. Organizing the correct service mix can be complicated and time-consuming. There is little consistency to the level of services provided across CCACs. According to an OACCAC report on children's services, "For too many years, parents have had to go to separate programs funded by both the Ministries of Health and Long-term Care and Community, Family and Children's Services to access the health and social services they need in order to support their child's development. Parents need a single point of access to services."[66]

Depending on the issue to be addressed, it often is unclear where families should go for assistance. For example, developmental delays are not within the primary mandate of CCACs. For these children, the Ministry of Community and Social Services (MCSS) plays a role through delivery of special services at home. CCACs reported taking overflow calls from people looking for more services than MCSS provides.

The Procurement Review was surprised to learn that, in one instance, a Children's Treatment Centre did not qualify for the procurement process for therapies because the Centre did not have experience in providing care at home.

When small volumes are involved, a separate RFP for children's services is not always feasible. The service may be too specialized, and another method may be needed to ensure the service reaches the children that need it.

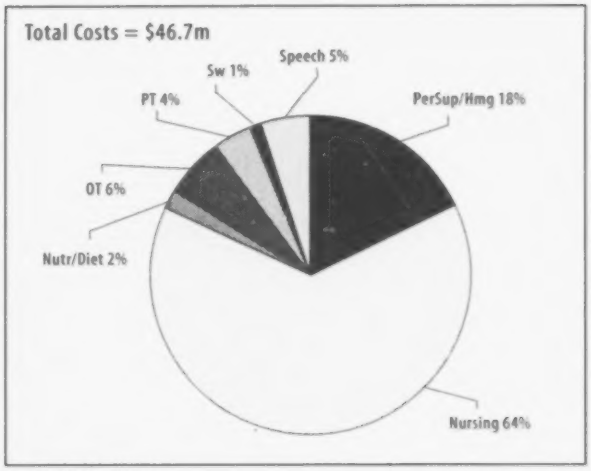
Key Findings

(i) Children's services are fragmented.

Overall, children account for 15% of CCAC clients and 11% of admissions per year. About 30% of CCAC child clients are served in their homes and 70% at school.[67]

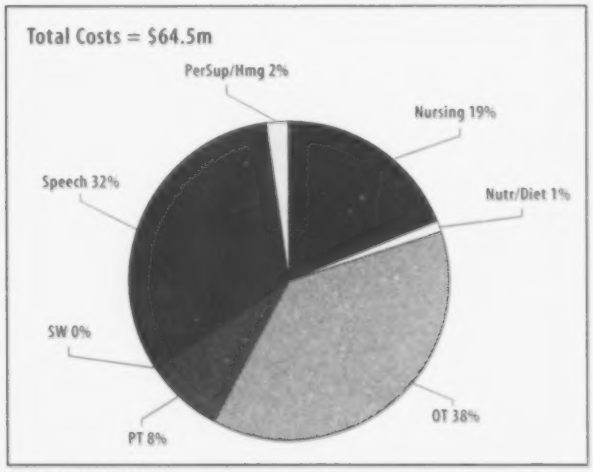
In Ontario, responsibilities for services to children are divided between different ministries of government. To address this issue, the Government created a new Ministry of Children and Youth Services (MCYS) to provide funding for child welfare, family intervention services, youth justice services, children's community support services, children's mental health services, and child care.

FIGURE 12: Children's Services Provided at Home (2000-01)



Source: OHCAS, 2003

FIGURE 13: Children's Services Provided at School (2000-01)



Source: OHCAS, 2003

In home care, the Procurement Review found that service delivery to children also is fragmented between different organizations. For example, speech therapy is the responsibility of CCACs in co-operation with the schools, while language the responsibility of the School Boards. MCSS, MOHLTC and the Ministry of Education (MOEd) are all involved in aspects of care. There is no overall coordinating body to assist families in receiving services for their children.

The Procurement Review found that services for the school program are provided in "blocks." For example, a child may be assessed for a series of 10 therapy sessions, and need another assessment. This can lead to lack of continuity and to interruptions in a child's therapy sessions. Furthermore, the number of sessions provided is often too few to reasonably expect a child to noticeably improve.

Eighty to 90 per cent of children served by CCACs require case management and may require nursing, personal support, equipment and supplies, and/or therapy sessions. Across Ontario, CCACs serve about 77,000 children, youth and young adults per year (birth to19, and up to 25 years of age in some cases, if still in school). The remaining 10% to 20% of cases require services provided by Children's Treatment Centres that entail long-term rehabilitation in a clinic setting.

Funding for children's services is a part of the CCACs overall budget. Figures 12 and 13 show that children's' services provided at school account for approximately 65% (or $64.5 million) of funding for children's services. Funding for children's services at home totals $46.7 million. CCAC services required in schools and at home differ. The majority of the services provided at schools are therapy services such as speech and occupational therapy. The majority of services at home are nursing, followed by personal support.[68]

CCACs find that there are often wait lists for children's services. They noted that there are delays in responding to the needs of children because some therapies and nursing services are not readily available when needed. The Procurement Review learned that often only one provider for children's services is present in a region, making an

RFP inappropriate. Small volumes make it untenable to issue an RFP for children's services. New, innovative approaches are needed to accommodate small volumes and specialized services. Encouraging Children's Treatment Centres to bid for home care contracts may be one option to consider.

In conclusion, the new Ministry of Children and Youth Services (MCYS) can better co-ordinate home care services to children.

Recommendation 50: MCYS conduct a review of the School Health Support Services program currently funded by the MOHLTC and delivered by the CCACs to develop a long-term strategy for both the co-ordination of services to children in schools and the funding of these services. The review to involve the MOEd, MOHLTC, MCSS and agencies currently delivering home care school programs.

Transfer of Funds

- CCACs to identify the envelope of funding for kids immediately with a view to transferring funds to the MCYS.

Process for Transfer

- Children's School Program to transfer to MCYS as contracts expire.
- CCAC'S to remain the delivery agent.

Additional Considerations

- MOEd to consider a similar transfer of programs to MCYS to ensure policy consistency.

Moving Forward

The mandate for the CCAC Procurement Review included an examination of the roles and responsibilities of the Ministry and CCACs. The Review also looked at the role of the CCAC board with a view to encouraging greater consistency in governance and improvements in oversight of procurement procedures.

Assessing and changing the roles of key participants is a cornerstone of moving the home care sector forward.

(A) Role of the Ministry of Health and Long-Term Care (MOHLTC)

Feedback from Submissions and Consultations

(i) Access to services is fundamental to clients.

While quality may be increasing for people receiving service in Ontario, several academics have pointed out that, until recently, overall service volumes had declined. As prices went up and funding levels remained constant, CCACs had to discontinue certain services in order to maintain balanced budgets. These changes occurred independently without provincial co-ordination and clear communication. The emphasis shifted from homemaking services to the provision of personal support. Clients and service providers told the CCAC Procurement Review that these changes were particularly difficult because it was unclear which services CCACs provide.

Stakeholders also suggested that the current CCAC funding formula should be more closely linked to the need of the local population, and should better account for demographic and geographic differences.

(ii) Information about wait lists is inconsistent.

According to the 2004 Provincial Auditor's Report, the MOHLTC has limited information on wait lists and wait times.[69] The Procurement Review learned that if a service is not offered, a wait list may not be kept. This lack of information on wait lists gives an incomplete picture of unmet client need. Stakeholders reinforced the importance of keeping this information consistent and accurate.

(iii) CCAC services vary across the province.

Several stakeholders also pointed out that there are discrepancies in the basket of services provided across the province. Since services are provided by CCACs based on historical patterns and available local community supports, services may differ from one region to another.

(iv) Stakeholders want more training to use template and tools.

CCACs and services providers said that they could have benefited from more training in the application of the new template and tools.

Capturing Gaps in Service

- MOHLTC to maintain accurate information on wait lists that are based on common definitions for all home care services in legislation that are to be provided by the CCACs, whether or not they are currently being provided.

Key Findings

(i) MOHLTC is changing the funding formula and updating policies.

The MOHLTC began revising the funding formula in June 2004 to facilitate the equitable per capita distribution of funds between regions for 2004/2005. There is evidence that the appropriate redistribution of funds has started. The Review also noted that the CCACs have played a leadership role in beginning to address the issue of discrepancy in equipment between regions. The Review encourages this work to continue and expand to other services since all Ontarians should have equity of access to home care services.

While the MOHLTC should not micro-manage the administration of CCACs, there is a need for active oversight of CCAC decisions to ensure equitable and sufficient access to mandated services for all Ontarians.

The MOHLTC is in the process of updating policies and procedures for CCACs, including procedures on wait lists. Until this work is completed, the 1984 Home Care Policies and Procedures Manual remains in effect. This has resulted in the development of inconsistent policies across the province; i.e., privacy policy. There also is a need for the MOHLTC to provide clear direction on current policies and procedures.

Priorities for MOHLTC Policy Updates:

- Update and regularly publish the Home Care Policy and Procedures Manual.
- Clarify policy roles between the MOHLTC and CCAC boards to identify areas of responsibility and ensure consistency where required.
- MOHLTC to work with the Office of the Privacy Commissioner and the OACCAC to standardize privacy policy under Provincial Health Information and Privacy Act.

(ii) Improve the collection of wait list data.

The Ontario Provincial Auditor's report found that while the MOHLTC does periodically summarize wait lists, there is no information on the length of time individuals spend on these lists.[70] The Review found that accurate information on wait lists is essential to ensuring that access to services is equitable and based on need.

Concerns about the quality and consistency of home care data are well founded. Data collected from a variety of sources (universities, associations and the MOHLTC) is inconsistent. Even basic statistics such as the number of people receiving service varies.

(iii) Provide regular and comprehensive training on procurement process and tools.

When the new template was first introduced, the OACCAC prepared a CD-ROM training package. While the CD-ROM training package was well received, it was insufficient to ensure competencies in applying the new template consistently. To establish a continuous improvement culture, regular training with appropriate updates is necessary.

Recommendation 51: MOHLTC to monitor compliance with the Long-Term Care Act and maintain accurate information on wait lists on both acute and chronic clients in need of home care.

Recommendation 52: The MOHLTC to monitor who is receiving home care services and who is not receiving services, including acute and chronic maintenance clients. Develop and implement appropriate regulations to support this function.

Recommendation 53: MOHLTC to establish a Committee with representatives from the OACCAC and the proposed CQR to develop new funding approaches for the home care sector based on demographics and need. This Committee to be supported by senior MOHLTC officials.

Recommendation 54: MOHLTC to place a high priority on completing the revised Home Care Policy and Procedure Manual.

(B) Building Better Boards

Feedback from Submissions and Consultations

(i) The skills and knowledge of CCAC boards vary considerably.

The strengths and competencies of CCAC boards when it comes to procurement vary significantly across the province. Some CCAC boards are known to micro-manage while others take an approach that is too "hands off."

Concerns were raised about a lack of co-ordination across CCACs, and potentially between the CCACs and the new Local Health Integration Networks.

Several associations expressed concern that CCAC administrative costs were too high.

Key Findings

(i) Boards should provide more oversight of procurement.

Research into the role of the board in community health care conducted for the Procurement Review suggests that boards need to provide more consistent oversight and governance, particularly in the area of procurement. This is vital to ensuring that all procurement processes are fair, transparent, and achieve the desired results.

The literature suggests that the characteristics of an effective governing body in the not-for-profit health care sector include:

- The board should be comprised of people with the necessary knowledge, ability, and commitment to fulfill their responsibilities;
- The board should understand their purposes and those whose interests they serve;
- Board members should understand the objectives and strategies of the organization they govern;
- Board members should know and obtain the information they require to exercise their responsibilities;
- Once informed, board members should act; and
- Board members should discharge their own accountability obligations by reporting on their organization's performance.

Recommendation 55: MOHLTC to provide orientation and ongoing training and education for modern board governance.

Recommendation 56: Strengthen board experience by having at least one member who has extensive knowledge and experience in procurement.

Recommendation 57: CCAC boards to receive regular reports from staff on contract monitoring and preferred providers. In keeping with recommendation 7, Boards to oversee that agreed upon volume principles are followed.

Recommendation 58: MOHLTC to consider cross-appointments between CCAC and LHIN boards.

Recommendation 59: CCAC boards to monitor and reduce administrative costs (including administrative costs related to case management) wherever possible. The case management service should be reported as a line item in the budget.

(C) Promoting a Quality Culture at CCACs

Feedback from Submissions and Consultations

(i) CCACs are becoming accredited.

In Canada, the facility-based and community-based health care sectors have been participating in accreditation programs for more than 25 years. The Canadian Council on Health Services Accreditation (CCHSA) has provided leadership to this process based on national standards. Some, but not all, CCACs are accredited by the CCHSA.

While many CCACs would like to become accredited, the CCHSA accreditation process could be challenging for an organization that acts mainly as a broker, and does not deliver health services.

(ii) CCACS are still providing direct services.

CCACs determine eligibility for CCAC services, and undertake the initial assessment of the client, referral and co-ordination. As a result, CCACs play an important gatekeeper role in the sector. The CCACs' mandate includes:

- Providing directly or indirectly health and related social services, supplies and equipment for the care of persons;
- Providing directly or indirectly goods and services to assist relatives friends and others in the provision for care for such persons;
- Managing the placement of persons into long-term care facilities;
- Providing information to the public about community-based services, long-term care facilities, and related health and social services; and
- Co-operating with other organizations that have similar objectives.[71]

Steps to Accreditation

- CCACs develop robust quality systems through adoption of quality management systems and accreditation.
- Boards to consider progress in achieving accreditation in performance appraisals of all CCAC Executive Directors.

Some CCACs said that they are not able to find qualified service providers in their area to offer a range of home care services. The Procurement Review also heard that CCACs hire staff from service providers during existing contracts. This practice can negatively impact the service provider's ability to deliver service and meet contract requirements.

CCACs Move Away from Direct Service Provision

- CCACs to divest from delivering direct service. MOHLTC to approve exceptions to take into account far north conditions and other anomalies
- In the interim, CCACs not to hire or replace staff for service delivery.

Seeking Alternatives in Areas with Limited Number of Providers

- In communities with two or fewer provider agencies, CCACs to negotiate directly with local hospitals, community health centres, long-term care facilities or Preferred Providers.

Direct Hiring from Contracted Providers

- This new provision to be included in future contracts.

(iii) CCACs need to communicate.

Across the province, there is very little awareness of CCACs and what they do. Few people know how to access home care services or what services are available. As a result, there is misinformation.

CCACs cannot communicate directly with the public or the media without MOHLTC approval. This is a particular concern when CCACs are unable to correct misinformation regarding procurement processes, winning bidders, changes in service providers, and transition issues.

(iv) The process to deal with complaints is ineffective.

There also are concerns about clients' ability to take complaints to higher levels. In general, there was a belief that the MOHLTC needs to deal with legitimate complaints.

Some people suggested that there should be a MOHLTC Ombudsman to monitor and enforce existing contracts. Others wanted to see "whistle blowing" protection for staff at CCACs. CCACs noted that there is no formal process for challenging or appealing a decision not to award an agreement.[72]

Key Findings

(i) Accreditation is beneficial.

A combination of good governance and leading-edge accreditation can be powerful tools for focusing the CCACs on improving quality and promoting best practices. Accreditation offers CCACs a framework to document and improve their processes. Currently, 15 CCACs are accredited through the Canadian Council on Health Services Accreditation.

CCACs and the OACCAC can benefit from the National Quality Institute (NQI) Model in the area of quality management and organizational excellence. The Procurement Review was pleased to learn that two CCACs have shown leadership and are already participating in the NQI program.

The Procurement Review concluded that there are a number of possible models for accreditation that may be appropriate for CCACs. These include a modified CCHSA, Community Health Accreditation Program, and National Quality Institute Program.

Recommendation 60: CCACs to be accredited by an appropriate organization within five years. MOHLTC to determine which accreditation is most suitable for CCACs, and whether modifications are needed.

Recommendation 61: All CCACs be required to participate in the Progressive Excellence Program of the National Quality Institute.

(ii) CCAC staffing practices should be clarified.

As seen in Table 6, the Procurement Review determined that nine CCACs continue to deliver some services directly.

In addition, several CCACs confirmed that they hire staff from their current service providers, primarily into the role of case manager.

Recommendation 62: The CCAC mandate to be amended to remove provision of 'direct' services. Direct services include nursing, personal support, homemaking, and therapies. This change is recommended in order to avoid a conflict of interest between the CCACs role as gatekeeper of government funding and decision-maker on quantity and nature of services to be provided.

TABLE 6: CCACs Providing Direct Service

Service	CCACs With Staff Not Divested	Region
Nursing	0	N/A
Physiotherapy	4	North, Central East, East
Occupational Therapy	3	North, Central East, East
Speech Language Pathology	3	North, Central East, East
Dietetic Services	2	Central East, East
Social Work	5	North, Central East, East

Source: IBM Survey of CCACs

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Source: IBM Survey of CCACs

Recommendation 63: CCACs to be prohibited from hiring staff from a service provider who holds a current contract in the their region until the existing contract has ended or providers are compensated.

(iii) Communication is inadequate.

The Pollara survey found that 57% of the general public contacted had never heard of CCACs or what they do. Sixty per cent of those surveyed perceived that the main role of CCACs was to provide in-home care to clients. Only 16% identified coordination and case management as the main role.[73]

The Pollara survey also found that 42% believe that only a medical professional can refer clients to home care.[74] There was no clear communication of the important fact that anyone can refer a client to home care services or that clients can self-refer.

Recommendation 64: CCACs to implement an annual communication plan that promotes who they are, what they do and how to access home care services. All CCACs to publicly release reasons why the winning bidder was chosen and reasons why the unsuccessful bids were rejected without prior approval from the MOHLTC.

(iv) Complaint mechanisms need to be more accessible and effective.

A clearly defined and easily accessible complaint mechanism can give clients and service providers a more effective means to voice concerns and resolve issues.

Recommendation 65: Strengthen dispute resolution mechanisms. All contracts to include agreement that material issues, excluding renewal, be resolved by mediation or, if necessary, by arbitration.

(D) Clarifying the Role of the Case Manager

CCACs provide an important case management function in home care. This includes:

- Eligibility for service;
- Assessment of need;
- Information about and referral to both long-term care facilities and community support services;
- Service planning, including care plans;
- Service implementation, monitoring and evaluation; and
- Discharge.

Feedback from Submissions and Consultations

(i) Distinction between the role of case managers and caregivers often is blurred.

Case managers and caregivers (nurses and therapists) find that their roles in assessing a client are unclear. This can result in unnecessary conflict, inefficient use of time, and a feeling of being second guessed. Caregivers would like more input into care plans while case managers feel that developing an appropriate care plan falls into their area of responsibility.

Key Findings

(i) Roles should be clarified.

Approximately 3,000 case managers are the gatekeepers for accessing home care services, connecting clients with other community support services and allocating required resources for the service/care plan. They play an important role in monitoring cases, particularly the up to 25% of clients who require intensive case management. The OACCAC is reviewing the role of the case manager, and it is expected that the case manager function will expand to include system navigation.

The Procurement Review found evidence of significant differences in the amount and type of resources allocated by case managers for clients with similar conditions. In the Spring 2003, an interactive learning session examining resource allocation and decision-making was conducted with a group of 200 community-based case managers. The case managers were given a typical client vignette and asked to assign the mix and intensity of services they felt would meet the care needs of this client for a 2-week time period. There were no restrictions or policy parameters placed on the decision-making. The results indicated that resource allocation variability exists overall. The total case cost differential ranged from $1,530.00 to $16,235.00 for services to cover the designated time period. Current patterns of resource allocation are dictated by past experience, professional background, values, embedded practice patterns, available resources and eligibility criteria."[75]

Both case managers and caregivers provide care planning for the client. The boundaries are unclear between the case manager and the caregiver. Moving to alternate funding should provide an opportunity to clarify the two roles and provide a better understanding of provincial variations in provision of services.

Recommendation 66: The OACCAC to consult with the MOHLTC and a broad range of stakeholders to obtain feedback about new definitions of the role of case management, including system navigation and/or disease management strategies.

(E) Leadership Role for the OACCAC

The OACCAC is a voluntary member organization representing Ontario's 42 CCACs. The OACCAC was established to "serve as a collective voice for the contribution made by CCACs to an integrated health care system; and to provide leadership, inspiration and evidence-based outcomes in support of innovative and cost-effective community health care services".[76]

OACCAC's mandate is to :

- Represent the interest of CCACs to governments, other components of the health care system and related agencies and organizations;
- Exchange information, experiences and views on aspects of CCAC operations;
- Disseminate and share information with members, media, the general public, allied agencies, associations and organizations;
- Provide educational and developmental opportunities for CCAC boards, management and staff;
- Provide leadership in research on the practice of community-based health services;
- Conduct policy analysis of issues and directions related to community-based health services; and
- Assist CCACs in establishing continuous quality improvement standards with a view to obtaining accreditation."[77]

Feedback from Submissions and Consultations

(i) The OACCAC has no authority over CCACs

The OACCAC told us that they are primarily a member funded and sponsored organization, with no authority to direct the CCACs, and no accountability for CCAC actions. Currently they can only make recommendations to government and to members. Members can, and have, opted out of the association as they see fit.

(ii) OACCAC provides important leadership

We heard from CCACs that the OACCAC plays a valuable role in disseminating and sharing information. The association facilitates joint initiatives, and sector-wide projects in areas such as quality improvement and investment technology.

Key Findings

(i) OACCAC Responsibilities to Increase from Review's Recommendations

The Review found that the OACCAC needs more authority to undertake the responsibilities set out in this review. Their current mandate as advocates for CCAC'S should be diminished as they assume a greater stewardship responsibility.

The recommendations give new responsibilities to the OACCAC. For example, the OACCAC will be responsible for province-wide pre-qualification and sector scorecard until the CQR is operational. They will also be responsible for the development of consistent tools for contract monitoring, common survey tools, and revisions to the RFP template. They will lead a task force of stakeholder associations to complete current work on establishing common key performance indicators for the standards and services schedule of the RFP as well as relevant common definitions. The OACCAC will also lead the development a consistent set of principles for establishing the number of service providers and for allocation of projected volumes.

Other areas where the responsibilities of the OACCAC will increase as a result of the review's recommendations include: standardizing supply specifications; basic employment standards for the industry; elimination of elect-to-work; coordinating sector investment in information technology; and standardizing privacy policy.

Recommendation 67: The OACCAC be given the necessary authority by a memorandum of understanding with the MOHLTC to carry out its enhanced role. CCAC participation in the OACCAC should be mandatory. The OACCAC mandate as advocates for CCAC'S should be diminished as they assume a greater stewardship responsibility.

Recommendation 68: The OACCAC Board of Directors should include at least 1/3 community membership in addition to CCAC members.

Recommendation 69: Starting with the oldest contracts first, the OACCAC to develop a staggered roll out plan for the resumption of RFPs beginning in April 2006. Further, a transparent procurement cycle to be developed for each CCAC and coordinated within the LHINs.

Recommendation 70: All contracts let under the 2003 RFP template to be eligible for a three year renewal upon expiration of existing contracts and for Preferred Provider status.

The Revised Procurement Model

In developing its recommendations, the CCAC Procurement Review selected the best elements of a number of procurement models that, together, will more effectively meet the needs of clients, their families, and workers. All procurement models have inherent strengths and weakness. The Review's goal was to build on the strengths and address the weaknesses of those models that are most relevant. The model chosen contains elements of well-managed competition and contestability. Elements of a contestability model are present with the introduction of client choice, public reporting of service provider performance and the public designation of some providers as Preferred Providers. Elements of healthy, well-managed competition remain in the procurement process to encourage an environment of continuous improvement. The evaluation continues to place a major emphasis on quality, while maintaining the goal of achieving best price.

This hybrid procurement model increases transparency, provides better information, promotes co-operation and quality, and ensures best price. Elements of screening mechanisms similar to Request for Qualifications (RFQ) and Vendors of Record processes are present in the pre-qualification and certification processes to ensure high-quality service providers are chosen for contracts. The existing procurement using Request for Proposal (RFP) was revised to address concerns about quality, consistency and continuity of service for clients. The model also introduces a request for tender (RFT) process for the procurement of generic medical supplies to ensure best price.

A "refresh methodology" model is being recommended to ensure that the qualification process remains relevant over time, without becoming overly cumbersome for current providers who are performing well.

The Centre for Quality and Research in Home Care meets these objectives of providing greater transparency and promoting cooperation amongst providers through the sharing of knowledge, research and best practices.

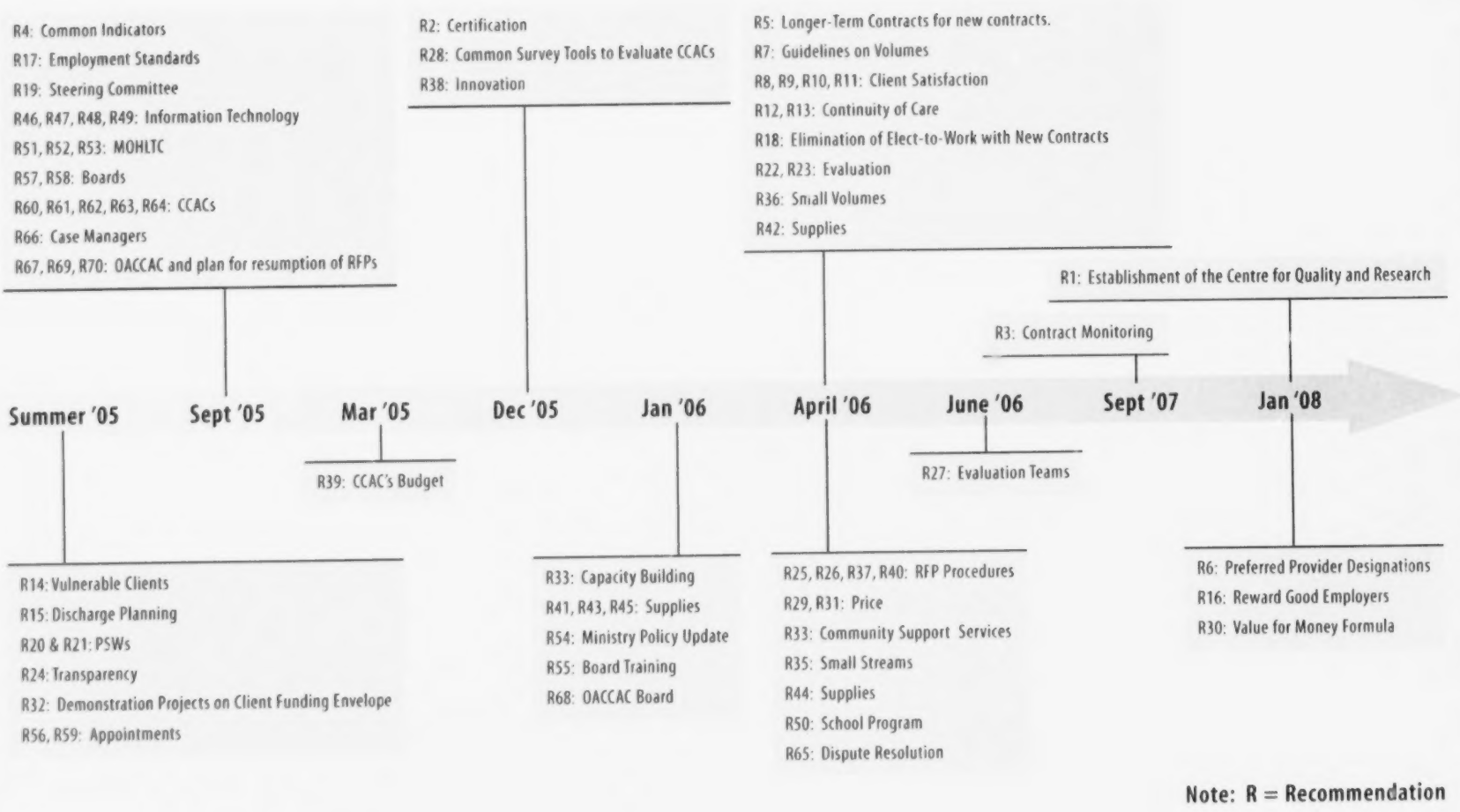
Overall, the recommendations in this Report create a unique procurement model for home care in Ontario.

Resource Implications and Timeline

The Review estimates that 3% of the current home care budget of $1.3 billion should be invested in transformation each year for three years to realize the potential of a Home Care System. We expect that FTEs will be reallocated from a variety of areas in the Ministry to support the implementation of the new Centre for Quality and Research. The Review's recommendations will support the Ministry of Health and Long Term Care's capacity to meet established targets for client care. Given the current Federal commitment to home care, it is appropriate to establish a Transformation Investment Fund for the sector.

The MOHLTC should report regularly on the progress of implementation of the Reviews' recommendations. When implemented, the result will be a Home Care System where decisions and policy are based on reliable evidence and client outcomes are measured. Accurate data on client outcomes is the essential component of achieving improved client results. By year three, cost efficiencies will be realized and more people will be able to benefit from quality home care.

Timeline for Implementation of Recommendations



Note: R = Recommendation

Conclusion

The goal of CCAC Procurement Review was to recommend improvements to the home care procurement system that will lead to better quality care, at the best value for money. Implementing the recommendations in this report will go a long way to achieving this goal.

Combining the elements of a number of procurement models to create a unique "made in Ontario" model will allow the Government and citizens of Ontario to fully realize the potential of home care. Once these recommendations are implemented, and the Centre for Quality and Research is established, Ontario will have a home care system where decisions and policies are evidence-based, and client outcomes and satisfaction are measured and evaluated.

The establishment of the Centre for Quality and Research in Home Care, (CQR) will make Ontario a leader in home care. The CQR will collect consistent information and set key performance indicators to measure progress, improvements and success in the home care sector. The CQR will upgrade standardize and streamline the service provider pre-qualification into a province-wide certification process.

Effective home care is a key element in the ongoing transformation to a more community-based system of care. With better information and measurements, home care clients will experience better quality care in Ontario.

The Procurement Review's recommendations have addressed other issues of paramount concern to Ontarians by providing clients and their families with more choice, more flexibility, and better information. This Report recommends exploring new funding options based on real client needs. It also recommends improving conditions for workers based on the premise that a satisfied workforce leads to better quality service for clients.

The Review introduced the concept of the Preferred Provider to reward those service providers who exceed expectations. As well, longer-term contracts will provide much-needed stability in the sector. Implementing these recommendations will lead to improved quality and value for money in home care in Ontario.

It still is necessary to ensure that home care receives the funding needed so it can provide an alternative to institutional care for Ontarians. Small investments in home care can keep people in their homes, the preferred location for the majority of Ontarians. It is important to get the system working well now, so it can meet increasing demands, particularly as people move out of hospitals sooner. The Procurement Review believes that funding for home care must continue to increase, and that it should continue to grow as a percentage of Ontario's total health care budget.

The Review also believes that the role of small service providers and those providing additional community support services should be continued and encouraged in the home care sector. Government funding should be directed to support these services.

The Procurement Review believes its recommendations can be implemented over the next three years, making a difference in the lives of those relying on home care in Ontario almost immediately.

Implications of Recommendations on Legislation

Recommendations	Legislative Implications
Recommendation 1: Establish a Centre For Quality and Research in Home Care (CQR) to lead the necessary research to inform good policy in home care. The Centre to report on client outcomes, establish benchmarks, disseminate best practices, encourage innovation and promote excellence in home care.	The CQR to be incorporated as a statutory corporation under the Ontario Development Corporations Act. Section 17 of the Community Care Access Corporations Act, 2001, S.O. 2001 ("CCAC Act") should be expanded to specifically include co-operation by CCAC's with the proposed Centre for Quality and Research established by the Minister for the purposes of publishing the annual report.*may be redundant as s.17 states that any agent of Minister has access to CCAC information
Recommendation 2: Streamline multiple pre-qualification processes by creating a one-stop province-wide pre-qualification/certification process. The CQR to develop a comprehensive certification model based on objective criteria. All providers to be certified by discipline and by volume. In the interim, province-wide pre-qualification to be administered by the OACCAC and supported by CCAC expertise.	Section 2 of the CCAC Act and s.5 of the Long-Term Care Act, 1994, S.O. 1994 ("LTC Act") and/or the accompanying regulations would need to include the role that the CQR will play in the designation and certification process.
Recommendations 3-6:	N/a
Recommendation 7: The OACCAC, in consultation with service providers, to develop a consistent set of principles for establishing the number of service providers for projected volumes.	This could be delineated in the regulations to the LTC Act. *may not be necessary - may be more of a business rather than legal arrangement
Recommendations 8-10:	N/a

Recommendations	Legislative Implications
Recommendation 11: Expand the Provincial (LHIN) 'Long-Term Care Action Line" to include home care client, caregiver and service provider concerns. The Action Line to provide a forum to hear confidential concerns. Clients to be given phone numbers for the service provider, case manager and the provincial (LHIN) action line to report concerns.	While s.1 of the LTC Act states that the purposes of the Act are to "ensure a wide range of community services available to people in their own home and other community settings so that alternatives to institutional care exist" it is recommended that the regulations of the Health Insurance Act, R.R.O. 1990, Regulation 552, be amended to include coverage when using the Long-Term Care Action line and more generally Tele-Health and Tele-Medicine.
Recommendation 12: Service providers to improve continuity by ensuring better communication between all workers providing care to individual clients.	Legislative support is provided for this in s.1 of the LTC Act.
Recommendation 13:	N/a
Recommendation 14: Give end-of-life clients, children and vulnerable clients special consideration during contract transitions.	It is recommended that this specific course of action be delineated in the Regulations to the *LTC Act*.
Recommendation 15-23:	N/a
Recommendation 24: Include a disclaimer in the RFP to make it known that as an agent of the government, CCACs are subject to PIPEDA and the Freedom of Information and Protection of Privacy Act which means all information under the care and control of CCACs may be subject to disclosure.	The CCACs are covered under the PIPEDA and subject to the Freedom of Information and Protection of Privacy Act as they are an agent of the government.
Recommendations 25-54:	N/a
Recommendation 55: MOHLTC to provide orientation and ongoing training and education for modern board governance.	It is recommended that this be included in regulations to the CCAC Act. Under s.9 of the CCAC Act it states that (1) Each board of directors shall establish a community advisory council as a committee of the board and **may establish such other committees of the board as it considers appropriate**, (2) The community advisory council is composed of such persons as may be prescribed by regulation and **has such duties as may be prescribed by regulation**.
Recommendations 55-70:	N/a

Glossary of Terms and Acronyms

Accreditation: A detailed comparison of an organization's services and method of operation against a set of national or provincial standards. Key areas that are examined during the accreditation process include client/patient care and the delivery of service, information management practices, human resources development and management, the organization's governance and the management of the environment.

Acute Hospital Beds: Beds in a hospital that are designated for patients staying a short period of time. Acute hospital beds are often located in Acute Care Facilities (excludes long term and rehabilitation hospitals).

Attrition: The loss of employees from the workforce.

bat.com: A group of CCAC leaders charged with the mandate to oversee CCAC IT initiatives.

Best Practice: A technique or methodology that, through experience and research, has proven to reliably lead to a desired result.

Benchmarking: Is the process of identifying, understanding and adapting outstanding practices from organizations to help improve performance within a field or sector.

Benchmarks: Identified targets within a sector or field that drive systemic quality improvement.

Care Envelope Model: A funding envelope model that provides flexibility to tailor care to meet the clients' needs; based on client outcomes rather than on visits.

Caregiver: A person who helps in identifying or preventing or treating the illness or disability of another.

Care Plan: An outline to be drawn up by the case manager and the client/family that defines the needed home care services for that client that is possible within a funding envelope.

Case Management: A strategy to support health care and use available resources. It varies in intensity according to client needs and is shared between the practitioner and client/caregivers.

Case Manager: The role and function of case managers is intake, assessment, care and service planning, care implementation, monitoring and evaluating, reassessment and discharge.

CCACs: The corporations designated as community care access corporations under the CCAC Act, 2001 and any other organizations approved to provide Client Services.

CCHSA: Canadian Council on Health Services Accreditation

CHAP: Community Health Accreditation Program (U.S.)

Client Services: Nursing services, occupational therapy services, physiotherapy services, speech-language pathology services, dietetic services, personal support services, homemaking services and supplies and equipment, as set out in the Long-Term Care Act, 1994. Single Client Service means one of these Client Services.

Community Support Services: Any and all services that are provided to the community by volunteers and service agencies e.g. meals on wheels.

Competitive Procurement Process: A public, competitive procurement process that includes requests for proposals, requests for prequalification and tenders.

Contract Monitoring: Includes incident reporting, key performance indicators, staff, and provider and client surveys, to ensure that the performance of stakeholders, their workers and CCAC workers is of the best possible quality and otherwise is continuously being improved.

Cost per Case: A model of funding that describes and calculates selected cases in chronic and acute home care according to the episode of care.

Criteria for Excellence: Includes the results of client and worker satisfaction surveys, client outcome information, certification status, implementation of best practices, meeting provincial benchmarks, innovation, accreditation and use of quality management systems. The criteria would be updated periodically to ensure an environment of continuous improvement. Monitoring would ensure preferred providers continue to meet established criteria.

CRQ: Centre for Research and Quality in Home Care

CTC: Children's Treatment Centre

Debriefing Session: May include strengths and weaknesses of the proposals, information about individual scores, or varying information about the scoring process. Debriefing sessions could also provide information about the evaluation process section by section.

Divestment: An act that strips one's investment from an agency, business, corporation, or organization.

eHealth: A consumer-centered model of health care where stakeholders collaborate utilizing technologies to manage health, arrange, deliver, and account for care, and manage the health care system.

Elect-to-Work: Defined in the Employment Standards Act as those workers who decide without penalty whether or not to work when requested.

End-of-life Care: A health care practice that aims to relieve suffering and improve quality of living and dying.

Evaluation Tool: Is to be based on common objective criteria across the CCACs and used for the RFP written document, the interview and the site visit.

Envelope Funding: Formula for funding based on the need of the client that is based on a total package of funding for a client.

FPs: For-Profit organizations

FTE: Full-time Equivalents

Home Care: Health services provided to residents within their own homes.

Home Care Worker: Includes any and all trained individuals who work in the delivery of community based home care services.

HRT-IM: Health Results Team on Information Management

Infusion Therapy: Involves the administration of medications, nutrients, or other solutions intravenously, subcutaneously, enterally, or epidurally (into the bloodstream, under the skin, into the digestive system, or into the membranes surrounding the spinal cord).

IT/IM: Information Technology/Information Management

Information Technology/Information Management Strategic Plan: Based on Recommendation 35 of the Review, is a plan to include the systems and technologies required for implementation of an electronic client record.

Joint Venture: A partnership agreement between two or more agencies under one contract, often involving the sub-contracting of a small or niche provider with a larger agency.

LHINs: Local Health Integration Networks

LTC Home: Long Term Care Home

Managed Competition: Client Services acquired competitively through open, fair and transparent procurement processes that are consistent across the province and utilize an RFP.

MCYS: Ministry of Child and Youth Services

MCSS: Ministry of Community and Social Services

MOEd: Ministry of Education

MOHLTC: Ministry of Health and Long-Term Care

MOU: Memorandum of Understanding

NFPs: Not-for-Profit organizations

Niche Provider: Small providers who are generally contracted for low volumes and deliver specialty services, e.g. Multiple Sclerosis therapy services.

NQI: National Quality Institute

OACCAC: Ontario Association of Community Care Access Centres

OASIS: Outcome and Assessment Information Set: Represents core items of a comprehensive assessment for an adult home care client.

OCSA: Ontario Community Support Association

OHCA: Ontario Home Care Association

Occupational Therapy: Involves persons who are limited by physical injury or illness, psychosocial dysfunction, developmental or learning disability or the aging process, in order to maximize independent function, prevent further disability and achieve and maintain health and productivity, and encompasses evaluation, treatment and consultation services that are provided to a person or group of persons.

Palliative Care: an approach that improves the quality of life of clients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Physiotherapy: Is a specialized health profession concerned with most aspects of health care e.g. promotive, preventive, rehabilitative and curative. Its aims are to relieve pain, restoring movement, improving fitness, aiding in the healing of body tissue, holistic rehabilitation of a person after injury or illness and educating on care and prevention of disabilities and handicap.

Preferred Provider: Status awarded to providers based on a Criteria for Excellence whereby providers could receive contract extensions of up to nine years as well as various other benefits, such as the ability to directly negotiate contracts with CCACs, and receiving credit in the RFP process.

Procurement: The acquisition of services or goods by any means.

Procurement Documents: The documents that a CCAC prepares for a procurement including the resulting contract.

Progressive Excellence Program of the National Quality Institute: A certificate of excellence that helps organizations build improvement plans and measure their progress step by step through the implementation of NQI criteria.

PSW: Personal Support Worker

PSW Services: A range of health care services in a variety of settings: long-term care facilities; in the community; in adult day programs; supportive housing settings; group homes; hospitals; educational facilities, etc. The range of services provided by Personal Support Workers includes home management (such as shopping, house cleaning and meal preparation); personal care (such as dressing, personal hygiene, mobility and other routine activities of living); family responsibilities (such as routine care giving to children), and social and recreational activities.

Quality Indicators: Indicators used by consumers, agencies, regulators, and policy makers that support evidence-based decision making related to the quality of home care services.

RAI-HC Tool: The Resident Assessment Instrument for Home Care

Request for Pre-qualification: A procurement process that asks Service Providers to pre-qualify on certain matters before bidding on the provision of a service. It usually consists of sections asking questions requesting information on the organization's history, performance, compliance with laws, project experience, finances and availability of surety and insurance.

Request for Proposal: A procurement process that requests competitive bids from suppliers, inviting them to submit a written proposal for the purpose of procurement, including a bid price.

RFP Template Document: Includes a pre-qualification document, a request for proposals, and the template services agreement between CCACs and successful bidders.

RN: Registered Nurse, provide direct nursing care to patients, deliver health education programs and provide consultative services regarding issues relevant to the practice of nursing. Registered Nurses may specialize in areas such as surgery, obstetrics, psychiatry, critical care, paediatrics, geriatrics, community health, occupational health, emergency care, rehabilitation and oncology.

RPN: Registered Practical Nurse, provide nursing care, usually under the direction of a Medical Practitioner, Registered Nurse, or other health team member. Registered Practical Nurses perform nursing functions, such as taking blood pressure and other vital signs, applying aseptic techniques, ensuring infection control, monitoring nutritional intake, and conducting specimen collection. Registered Practical Nurses administer medication, observe and document therapeutic effects, monitor the progress of patients, evaluate the effectiveness of nursing interventions and consult with appropriate members of the health care team.

Service Provider: An agency /organization that provides Client Services purchased by a CCAC. Can also be an individual as in the case of professionals such as physiotherapists, occupational therapists, speech-language pathologists, etc.

Services Contract: A contract for supplying or performing a service. A service contract may include the supply of parts or materials to perform the service.

Service Plan: See Care Plan.

Speech-Language Pathology: Is the applying of principles, methods or procedures of prevention, identification, evaluation, consultation, intervention, instruction or research related to speech, language, cognition or swallowing or any abnormal condition involving speech, articulation, fluency, voice, verbal or written language, auditory comprehension, cognition or communication or oral, pharyngeal or laryngeal sensorimotor competencies.

SSHA: Smart Systems for Health Agency

System Navigator: An expanded role of the case manager.

Tender: A procurement process that requests competitive bids from the suppliers, asking them to submit a bid price for the supply of specified goods. The price is ranked to determine the best price.

Therapy Services: Includes all specialty services, such as Occupational Therapy, Physio and Rehab Therapy, Speech-Language Pathology, Dietician Consulting, and Social Work.

Transition Plan: Plans for both taking up a new contract and ending an existing contract.

Value for Money: A price/quality scoring formula to be used to evaluate bidders.

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APPENDIX 1: Submissions to the CCAC Procurement Review

Access Health Care Services

Alegro Health Corporation

Algoma, Cochrane, Manitoulin, and Sudbury District Health Council

ALS Society of Ontario

Alliance of Professional Associations for Community-Based Therapy Services (APACTS)

Bayshore Home Health

Bridgepoint Health

Calea HomeCare

Canada's Association for the Fifty-Plus (CARP)

Canadian Red Cross – Community Health Services

Canadian Association for Enterostomal Therapy

CanCare Health Services

CanChild Centre for Childhood Disability Research

Carefirst Seniors and Community Services

Care Partners

Care Watch

Carpenter Hospice

Centre for Health Economics and Policy Analysis (CHEPA)

Cerebral Palsy Parent Support Group

Champlain District Health Council

ComCare Health Services

Community Care Therapy and Kaymar Rehabilitation

Community Care East York (CCEY)

Community Foundations of Canada

Community Health Care Providers Network

Community Health Nurses' Initiatives Group

Community Home Assistance to Seniors (CHATS)

Community Nurses of Grimsby Lincoln and West Lincoln

Comprehensive Rehabilitation and Mental Health Services (COTA)

Council on Aging – Frontenac-Kingston

DHS Health Care Service

Don Mills Foundation for Seniors

Dryden Regional Health Centre

Dynamic Therapy Solutions

Erinoak – Serving Young People with Disabilities

Extendicare Canada & Paramed Home Health Care

Grandview Children's Centre

Health Care Centre Pharmcy, Grand River Hospital

Heaman Communication Services

Heart and Stroke Foundation of Ontario

Kingston Area Health Coalition

McMaster University, Department of Political Science (Denise F. O'Connor)

Medigas – A Praxair Company

Multiple Sclerosis Society of Canada, Ontario Division

Nightingale Nursing Registry

Northwestern Ontario District Health Council

Ontario Association of Community Care Access Centres

Ontario Association for Families of Children with Communication Disorders (OAFCCD)

Ontario Association of Social Workers (OASW)

Ontario Children's Rehabilitation Centres (OACRS)

Ontario Community Support Association (OCSA)

Ontario Federation of Labour (OFL)

Ontario Coalition for Long Term Care

Ontario Health Coalition (OHC)

Ontario Health Care Association (OHCA)

Ontario March of Dimes

Ontario Nurses Association (ONA)

Ontario Personal Support Worker Association (OPSWA)

Ontario Public Service Employees Union (OPSEU)

Ontario Psychogeriatric Association

Ontario Association of Speech-Language Pathologists and Audiologists (OSLA)

Pace Homecare Services

Partners in Community Nursing

Physical Relief Health Care Services

Pro Home Health Services

Registered Nurses Association of Ontario (RNAO)

Rehab Express and Respiron Care Plus

SEN Community Health Care

Service Employees International Union Local 1 (SEIU)

Senior Advisory Committee on Long Term Care

Senior Link (Peel)

Senior Peoples' Resources in North Toronto (SPRINT)

Simcoe York District Health Council

St. Elizabeth Healthcare

St. Elizabeth Healthcare Metro Nurses

St. Joseph's Health System

Therapy Partners

University of Toronto, Faculty of Medicine, Department of Occupational Therapy

VHA Health and Home Support Services, Hamilton

VHA Ottawa

Victorian Order of Nurses Canada

Victorian Order of Nurses Ontario

Victorian Order of Nurses Ottawa-Carleton

Victorian Order of Nurses Niagara

APPENDIX 2: Recognition of Organizations Participating Through Meetings

1 to 1 Communication Therapy

Access Health Care

Access Nutrition

Alexandra Hospital (Ingersoll)

AllCare Health Services

ALS Society of Ontario

Alliance of Professional Associations for Community-Based Therapy Services

Alzheimer Society

Bayridge Therapy

Bayshore Home Health

Bluewater District School Board

Brain Injury Services for North Ontario

Bridgepoint Community Rehab

Britt Nursing station

Bruce GreyCatholic District School Board

CJ Brown & Associates

Calea HomeCare

Canada Care Medical

Canadian Hearing Society

Care Partners

CarePlus

Carefirst Seniors and Community Services Association

Care Watch Toronto

Central & Northern Etobicoke Home Support Services (C.A.N.E.S)

Cisco Systems

Canada's Association for the 50+

Canadian Council on Health Services Accreditation

Canadian National Institute for the Blind

Canadian Red Cross – Community Health Services

Care Partners

Canadian Autoworkers

Central Health Services

Children's Treatment Centre

City of Ottawa

CKTB Radio

Clark's Pharmasave

Coalition of Health and Support

Coloplast Canada Corporation

Comcare Health Services

Communicare Therapy

Community Advantage Rehab

Community Care Access Centres (Ontario)

Community Care Therapy

Community Health Nurses Initiatives Group

Community Home Assistance to Seniors (CHATS)

Community Rehab Services

Community Support Services

Comprehensive Rehabilitation and Mental Health Services (COTA)

Coram Healthcare Ltd.

Council on Aging

Council of Women

Community Union of Public Employees (CUPE)

Department of Health Policy, Management and Evaluation,

University of Toronto

Department of Health Studies and Gerontology, University of Waterloo

Dryden Regional Health Centre

Dynamic Therapy Solutions
e-Health, Ministry of Health
Erinoak
Et Now
Etobicoke Services for Seniors
Extendicare
Faculty of Nursing, University of Toronto
Fairmount Home
French Community of Renfrew
Gamma-Dynacare
GEM Health Care
George Jeffery Child Treatment Centre
Grand River Hospital
Granview Chilren's Centre
Grey Bruce Health Service
Guelph Service for People with Disabilities
Hazutt & Steeges Accountants
Health Care Centre Phamacy
Health Results Team on Information Management
Heaman Communications Services
Heart & Stroke Foundation
Helping Hands
Halton Hills Community Support and Information
Hill Knowlton
Home and Community Support
Hospice at Maycourt
Hospice Huntsville
Hospice Lennox & Addington
Hospice Muskoka
Hospice Peel
Hotel Dieu Hospital
Ian Anderson House
IBM Business Consulting
Independent Living Centre
Integrated Rehab
Ironside Consulting
Kaiser Permanente
Kawartha Participation Projects
Kawartha Therapy
Kaymar Rehab
KCI Medical
Kenora Chiefs Advisory Inc.
Kenora Physiotherapy
Kingston Area Health
Kingston General Hospital
Kingston Oxygen Home
KMW Adult Health Care
Lake of the Woods Child Development
Lake of the Woods District Hospital
Lambton College
Lambton Elderly Outreach
Lambton Seniors Association
Leamington District Memorial Hospital
Leisureworld Caregiving Centre
Lewis & Krall Funeral Home
Liberal Caucus
Mackhall Mobility Products
Management Board Secretariat
March of Dimes
Marchese Pharmacy

Mattawa General Hospital
McMaster University
McTague Law Firm
MDS Lab Services
Med-E-Ox
Medigas – A Praxair Company
Ministry of Children and Youth Services
Ministry of Health and Long-Term Care
Mohawk College
MS Society
Multi-Service Centre
National Committee for Quality Assurance
National Quality Institute
Niagara Health System
Niagara Peninsula Children's Centre
Niagara This Week
Nightingale Nursing
Northern Shores Childrens' Treatment
Northwestern Independent Living Services
Nutrition Consultants
Older Women's Network
Ontario Association of Community Care Access Centres
Ontario Association of Social Workers
Ontario Coalition for Long Term Care Reform
Ontario Coalition of Senior Citizens' Organizations (OCSCO)
Ontario Community Support Association (OCSA)
Ontario Federal of Labour (OFL)
Ontario Home Health Care Providers' Association
Ontario March of Dimes
Ontario Medical Supplies
Ontario Nurses Association
Ontario Public Service Employees Union (OPSEU)
Ontario Senior's Secretariat
Ontario Personal Support Workers' Association
Ontario Speech Language Association (OSLA)
OT Services
Oxford Seniors Advisory
Pace Home Healthcare
ParaMed Home Health Care
Partners in Community Nursing
Partners in Rehab
Pathways Health Centre for Children
Progressive Conservative Caucus
Peterborough Regional Health Centre
Pharmaplus
Physical Relief
Physically Handicapped Adults Rehab Association
Pinecrest Home for the Aged
Pointe au Baril
Partnering & Procurement Inc.
Preferred Health Care Services
Preston Medical Pharmacy
Professional Home Health
Providence Continuing Care
Provincial Council of Women
Pro Wellness Health
Professional Home Health Care Corporation
Registered Nurses Association of Ontario
Rehab Express
Rideaucrest Home

Robertson Brown Health Services
Sarnia Health Coalition
Security Health Consulting
Segue Communications Inc.
SEN Community Care
Service Employees International Union - Local 1
Shoppers Home Healthcare
Smart Systems for Health Agency
South Gate Seniors Centre
Spectrum Health Care
St. Elizabeth's Healthcare
St. Joseph's Care Group
St. Joseph's Homecare
Storefont Humber Inc.
Sudbury Finnish Rest Home Society
Thames Valley Children's Centre
The Children's Rehab Centre
Therapy Supplies
The Nugget
Therapacc Inc.
Therapy Health Care
Therapy Partners
Therapy Supplies & Rental
The Sarnia Observer
The Standard (newspaper)
TkMC Consulting
TLC Nursing
Toronto Health Services
Total Nursing Care
University of Ottawa
VHA Home Health Care (GTA)
VHA Ottawa
Victorian Order of Nurses
We Care Home Health Service
Woit's Pharmacy
Workflow Integrity Network
Woodstock General Hospital

End Notes

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14 The general public survey (n=1000) is accurate within + 3.1% 19 times out of 20. The home care client study (n= 500) is accurate within + 4.5% 19 times out of 20 and the home care worker study (n=200) is accurate within + 7% 19 times out of 20.

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